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No. _____

Supreme Court, U.S.
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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1991

INTERNATIONAL RESOURCES, INC.
and LARRY E. SMITH,
Petitioners,

vs.

NEW YORK LIFE INSURANCE COMPANY,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JAMES G. LeMASTER
DANNY C. REEVES*
ANNE ADAMS CHESNUT

GREENBAUM DOLL & McDONALD
1400 Vine Center Tower
P.O. Box 1808
Lexington, Kentucky 40593-1808
(606) 231-8500

Counsel for Petitioners

* *Counsel of Record*

COURT INDEX PRESS, INC. — 215 E. Ninth Street, Cincinnati, Ohio 45202 — (513) 241-1450

QUESTIONS PRESENTED

I. Does the bare purchase of health insurance by a small, closely-held corporation constitute the establishment of an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA")?

II. Should ERISA be deemed to pre-empt an insured's state law claims against an insurance company when the only purported "ERISA plan" is the insurance itself?

III. Are the insured's claims based on state laws regulating insurance pre-empted, or do they survive by virtue of ERISA's saving clause?

PARTIES AND CORPORATE AFFILIATIONS

The parties to the proceedings below were petitioners International Resources, Inc. and Larry E. Smith, and respondent New York Life Insurance Company. International Resources, Inc. has no parent or subsidiary company to report pursuant to Rule 29.1.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The petitioners International Resources, Inc., and Larry E. Smith respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Sixth Circuit, entered November 26, 1991.

OPINIONS BELOW

The opinion of the Court of Appeals for the Sixth Circuit is officially reported at 950 F.2d 294 and is reprinted in appendix A.

The memorandum decision of the United States District Court for the Eastern District of Kentucky (Hood, D.J.) has not been reported. It is attached in appendix D.

The Sixth Circuit's Order of remand in earlier consolidated appeals of this same case was not reported but is included in

appendix E. The memorandum decisions of the district court which led to those first appeals were also unreported and are reprinted in appendices G, H, and I.

JURISDICTION

The judgment sought to be reviewed was entered November 26, 1991. An order denying a petition for rehearing was entered January 15, 1992. This petition is filed within 90 days of that date. The Court has jurisdiction to review the judgment by writ of certiorari under 28 U.S.C. § 1254(1).

Jurisdiction below was based on diversity under 28 U.S.C. § 1332.

STATUTES INVOLVED

The following provisions of ERISA are involved in this case:

(1) Definition of "employee welfare benefit plan" under 29 U.S.C. § 1002(1), set forth in appendix J; and

(2) The three clauses relating to pre-emption: 29 U.S.C. § 1144(a) (pre-emption clause), appendix K; 29 U.S.C. § 1144(b)(2)(A) (saving clause), appendix L; and 29 U.S.C. § 1144(b)(2)(B) (deemer clause), appendix M.

Specific provisions of several Kentucky statutes are also involved:

(1) Kentucky's Unfair Claims Settlement Practices Act, KRS 304.12-230, appendix N;

(2) Kentucky's Consumer Protection Act, KRS 367.170 and 367.220, appendix O;

(3) Kentucky's Trade Practices and Frauds Statute, KRS 304.12-010 and 304.12-020, appendix P;

(4) Kentucky's Insurance Code, KRS 304.018-110(5), appendix Q; and

(5) Kentucky's civil action statute, KRS 446.070, appendix R.

STATEMENT OF THE CASE

This case arises from a dispute over the purported cancellation of health insurance by respondent New York Life Insurance Company ("New York Life") under a policy promising "$1 million in lifetime benefits." New York Life unilaterally cancelled the policy long before the $1 million maximum was reached — and after the insured's son had become quadriplegic and thus uninsurable by any other company.

Petitioners International Resources, Inc. ("International Resources") and Larry E. Smith ("Mr. Smith") brought suit against respondent New York Life in the district court on the basis of diversity jurisdiction under 28 U.S.C. § 1332. The claims were in 10 counts, for (1) declaratory relief; (2) breach of contract; (3) bad faith, tortious breach of insurance contract; (4) breach of fiduciary duty; (5) breach of implied covenant of good faith and fair dealing; (6) violation of Kentucky's Unfair Claims Settlement Practices Act (appendix N); (7) violation of Kentucky's Consumer Protection Act (appendix O); (8) violation of Kentucky's Trade Practices and Frauds Statute (appendix P); (9) violation of Kentucky's common law and public policy against illusory insurance practices; and (10) violation of specific provisions of Kentucky's insurance code requiring an insurance company to issue an individual conversion policy with substantially similar benefits upon the cancellation of group coverage (appendix Q). Damages, including punitive damages under Kentucky law, were sought against the insurance company in counts 11 and 12 of the complaint.

Respondent New York Life defended by moving to dismiss the complaint on the grounds that the state law claims were pre-empted by the Employee Retirement Income Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA"). Petitioners resisted application of ERISA because the case involved nothing but the bare purchase of insurance. Petitioners also argued that, even if ERISA applied, several of their state law claims survived by virtue of ERISA's saving clause, 29 U.S.C. § 1144(b)(2)(A).

The motion to dismiss was granted, with leave to amend to state an ERISA claim, but the district court also granted petitioners leave to seek an interlocutory appeal (appendix G). The Sixth Circuit accepted the appeal (appendix F) and the issue of ERISA pre-emption was argued on December 3, 1990. Just as the case was being argued, however, this Court decided two ERISA cases, *FMC Corp.* v. *Holliday*, 498 U.S. ____, 111 S. Ct. 403 (1990), and *Ingersoll-Rand* v. *McClendon*, 498 U.S. ____, 111 S. Ct. 478 (1990). The Sixth Circuit remanded the present case to the district court for reconsideration in light of the new Supreme Court authority.

Upon remand, the district court again found that ERISA pre-empted all twelve counts of petitioners' complaint. But the district court and the Sixth Circuit also permitted the petitioners to proceed on a second interlocutory appeal (appendices C and D). The Sixth Circuit ultimately reversed the district court as to one count of the complaint which it found survived under the saving clause of ERISA (the count based on conversion rights under Kentucky's Insurance Code), but otherwise affirmed the finding of ERISA pre-emption.

The facts material to the consideration of the questions presented are relatively straightforward:

Mr. Smith formed International Resources in 1982 and has been president of the closely-held corporation since that time. Mr. Smith and his wife have been the sole or majority shareholders of the corporation since its formation. The only other shareholder is a gentleman named John Bowersmith, who purchased a 25 percent interest in the corporation to help the Smiths financially after their son was severely injured in an automobile accident in 1983.

In November 1982, International Resources (then wholly owned by the Smiths) contacted a local insurance agent to obtain medical insurance. The agency arranged for comprehensive group medical insurance coverage through Group Marketing Services, Inc. ("GMS"), a multiple employer trust whereby small employers could combine together to obtain a

more favorable rate offered to larger groups. The insurance was underwritten by Life Insurance Company of North America ("INA"). Mr. Smith was the insured and his family members were covered dependents under the insurance policies described herein.

On May 8, 1983, Mr. Smith's son and dependent, Mark Smith, was severely injured in an automobile accident which left him completely immobile, unable to speak, and in need of 24-hour nursing and home health care.

On March 1, 1986, New York Life succeeded previous underwriters on the insurance coverage. The letter advising petitioners of this change assured them there would be no change or interruption in coverage. The booklet distributed by New York Life at the time promised the same $1 million in lifetime benefits and recognized the prior plan's coverage. Mr. Smith was assured this benefit would not change.

New York Life paid the costs and expenses of medical care for Mark, subject to applicable deductibles and co-payments, until October 1, 1989. Beginning on that date, New York Life refused to pay the expenses for Mark's medical treatment, which costs approximately $100,000 per year.[1]

Petitioners received notice by letter dated August 29, 1988, that the group insurance would be cancelled effective September 30, 1989. This notice had been preceded by numerous and significant increases in the premiums, and petitioners had paid over $30,000 in premiums before the purported cancellation. As to Mark Smith specifically, New York Life's internal notes referred to him as a "vegetable" and indicated it was "looking at 50 years of liability" on the claim.

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[1] While New York Life relied upon certain language in its policy as authorizing the purported cancellation, the district court did not find the argument persuasive as it granted injunctive relief against respondent below. (Memorandum Opinion at appendix I). Respondent took appeals as a matter of right from the injunctive relief awarded against it, but the Sixth Circuit affirmed the injunction (appendix A). Those issues are not part of the questions presented.

Upon receiving notice of New York Life's intention to terminate coverage, Mr. Smith offered premium payments and made repeated demands that New York Life honor the insurance contract by either continuing the existing coverage or by converting the coverage to an individual policy with substantially the same coverage, all of which New York Life refused to do. As of the date New York Life ceased payments, approximately $425,000 in benefits remained to be supplied in accordance with the insurance contract.

In summary, New York Life paid for what it recognizes is medically necessary care for Mark during the period March 1986 to October 1989. Now it has unilaterally cancelled the coverage and none other is available. Mark is uninsurable because of his physical condition. His care costs $8,000 or more per month.

For most of the corporation's existence, Larry Smith has been the only full-time employee. The company never had more than six workers, several of which were family members. Neither Larry Smith nor International Resources has ever owned, directly or indirectly, any part of GMS or New York Life Insurance Company. Neither Larry Smith nor International Resources has ever had any participation in the management or day-to-day operation of GMS or New York Life Insurance Company.

ERISA was applied as a legal fiction to these facts, with the insurance deemed by the courts below to be an "employee welfare benefit plan" although it was undisputed that there was no actual "plan" or any "plan assets," but only the insurance itself.

REASONS FOR GRANTING THE WRIT

I.

The Sixth Circuit's application of ERISA to the bare purchase of insurance by a small, closely-held employer is in conflict with decisions by the former Fifth Circuit and the present Fifth Circuit on the same issue and is even in conflict with the reasoning of the Eleventh Circuit case upon which the Sixth Circuit relied.

The former Fifth Circuit addressed facts virtually identical to those presented here in *Taggart Corporation* v. *Life and Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981). In *Taggart*, a small family business employed only the owner and his wife. The owner/employer had similarly contracted with a private interest marketing group, set up specifically to obtain group health insurance for small employers. The owner brought suit under ERISA to obtain health insurance benefits due under an insurance policy.

The facts of *Taggart* are almost identical to the present facts because in both cases the employer was too small to afford group insurance for his employees and was forced to go to an insurance marketing group which solicited, collected and pooled all employer funds. The marketing group, or conduit, then contracted with insurance companies to underwrite the group policies for each employer. No employer had any control over the conduit.

The term "employee welfare benefit plan" is defined in ERISA as:

> any plan, fund, or program . . . established or maintained by an employer or by an employer organization . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

29 U.S.C. § 1002(1)(A). In dismissing the employer's ERISA claims against the insurance carrier and the marketing association, the *Taggart* court held that clearly this was not a "plan, fund or program" within the meaning of ERISA. *Id.* at 1211. The court emphasized the fact that none of the employers participated nor had any control in the marketing group's day-to-day operations, administration, or selection of insurance carrier. The same facts are true in the present case.

In examining the legislative history, H.R. Rep. No. 94-1785, 94th Cong., 2d Sess. 48 (1977), the *Taggart* court concluded it showed ERISA's drafters were principally concerned with abuses occurring with respect to private pension assets, and not with private insurance. *Id.*

> Considering the history, structure, and purposes of ERISA, we cannot believe that that Act regulates bare purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits.

Id. at 1211. The present case similarly involves nothing more than the "bare purchase" of health insurance and is completely outside the scope ot ERISA.

The Fifth Circuit recently followed the *Taggart* rationale in *Gahn* v. *Allstate Life Ins. Co.*, 926 F.2d 1449 (5th Cir. 1991). *See also*, *Kidder* v. *H&B Marine, Inc.*, 932 F.2d 347, 353 (5th Cir. 1991) (rejecting "district court's apparent reasoning that the payment of [insurance] premiums alone is sufficient to create a plan," although finding one did exist on the specific facts presented therein). In *Gahn*, a woman employed in her husband's business was diagnosed as having liver cancer. Allstate responded (as has New York Life) by raising the premiums and ultimately cancelling the policy. The cancer victim sued Allstate for violations of Louisiana law, but the district court entered summary judgment for Allstate based on ERISA pre-emption. The Fifth Circuit reversed, finding the record inadequate to support applica-

tion of ERISA,[2] and citing *Taggart* with approval on two points: (1) that a multiple employer trust is not an ERISA plan, and (2) that "ERISA does not regulate the purchase of health insurance if 'the purchasing employer neither directly nor indirectly owns, controls, administers, or assumes responsibility for the policy or its benefits.' " 926 F.2d at 1452, quoting from *Taggart*, *supra*. The court further noted that the only relevant facts in the record supported Mrs. Gahn's argument that there was no ERISA plan because her husband testified:

> That he did not play any part whatsoever in the formulation of the policy, held no monies in trust, but merely forwarded premium payments to Allstate. He did not own, control, administer nor [sic] assume any responsibility for the policy or its benefits. He merely purchased insurance for his family.

Id. at 1452-53, quoting from affidavit. Although the Fifth Circuit remanded the case to the district court for further development of the facts, it suggested if these were all the facts, "the plan was *not* an ERISA plan." *Id.* (emphasis supplied by the court).

The same facts are true in the present case, yet the Sixth Circuit inexplicably reached a different result. Petitioners did not formulate the insurance policy; they just bought it. They held no monies in trust, but merely paid premiums to New York Life. They did not own, control, administer, or assume responsibility for the policy or its benefits.

Although the Sixth Circuit recited a litany of supposedly separate steps taken by International Resources that evidenced the establishment of a "plan" (950 F.2d at 298) (appendix 6a), that litany is just several different ways of saying

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[2] The Fifth Circuit held that even if ERISA were applied, plaintiff's state law remedies based on state insurance statutes were not pre-empted. 926 F.2d at 1454. See discussion at 24 *infra*.

the same thing: that International Resources purchased health insurance for its employees. Specifically, the Sixth Circuit noted that "International Resources chose the [insurance] plan, paid the premiums, and gave this coverage to all its employees as an employee benefit." *Id.* That is nothing more than the bare purchase of insurance. A company cannot purchase insurance without choosing an insurance plan; it cannot purchase insurance without paying the premiums; and it cannot purchase insurance for its employees without giving them that coverage, which is certainly a benefit. This is not the establishment of an ERISA plan, either in fact or by application of law. What happened in fact is that this company purchased a policy of insurance; what happened as a matter of law is that the Sixth Circuit over-reached in applying the legal fiction of ERISA to come to a result which conflicts with the law of other circuits and with Congressional intent.[3]

An "overly broad interpretation of the term 'employee welfare benefit plan' ignores congressional intent." *Wisconsin Educ. Ass'n Ins. Trust* v. *Iowa State Board*, 804 F.2d 1059, 1064 (8th Cir. 1986). The court in that case noted that Congress never intended ERISA to include group marketing plans such as the GMS plan here:

> Certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. . . . These programs are not 'employee benefit' plans as defined in [the Act]. As described to us, these plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained

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[3] Petitioners also argued below that the existence of an ERISA plan "is a question of fact, to be answered in light of all the surrounding facts and circumstances" which, of course, had not been fully developed prior to the interlocutory appeals, citing *Kanne* v. *Connecticut General Life Insurance Company*, 867 F.2d 489, 491 (9th Cir. 1988), *cert. denied*, 109 S.Ct. 3218 (1989). This issue is within the questions presented and is not waived.

> by the appropriate parties to confer ERISA jurisdiction, nor is the purpose for their establishment or maintenance appropriate to meet the jurisdictional prerequisites for the Act. *They are no more an ERISA plan than is any other insurance policy sold to an employee benefit plan.* . . . We do not believe that [ERISA] and legislative history will support the inclusion of what amounts to commercial products within the umbrella of the definition [of an ERISA plan].

Id. at 1063-64, quoting from H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977) (emphasis added).

New York Life finally conceded below that the GMS Trust was not an ERISA plan, but it continued to argue that International Resources nevertheless created some separate ERISA plan by joining the multiple-employer trust. This argument was expressly rejected by the *Taggart* court, 617 F.2d at 1210-11 (neither the multiple employer trust nor an employer's subscription to it establish an ERISA plan). Yet, the Sixth Circuit adopted this circular reasoning, even though the only thing petitioners did in this case was to purchase insurance. They simply called an insurance agent who enrolled them in a multiple-employer trust. For all of the foregoing reasons, that is not the establishment of an ERISA plan. As in *Taggart*:

> The supposed . . . 'plan' has no assets and is liable for no benefits. There is nothing to be placed in trust, so there is no trust. The corporation did no more than make payments to a purveyor of insurance. . . . There simply exist no assets for ERISA's statutory safeguards to protect.

617 F.2d at 1211.

The Sixth Circuit in the present case declined to follow *Taggart* and *Gahn* and found "the construction of ERISA [in *Donovan* v. *Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc) to be] more consistent with the Act's broad

scope. . . ." 950 F.2d at 297. *Donovan*, however, arose in very different circumstances, with the Secretary of Labor suing to enforce fiduciary responsibilities against the trustees of a multiple-employer trust. More importantly, the *Donovan* court expressly stated that it "agree[d] with the holding and reasoning" of *Taggart* that the multiple-employer trust itself was not an ERISA plan and with the finding that there was no employee welfare benefit plan in *Taggart*. *Donovan*, 688 F.2d at 1375.

> [N]o single act in itself necessarily constitutes the establishment of [an ERISA plan]. For example, the purchase of insurance does not conclusively establish [an ERISA plan] . . . .

Donovan, 688 F.2d at 1373.

Since *Taggart's* facts are virtually indistinguishable from those presented here, it follows that even the *Donovan* court would not go so far as the Sixth Circuit has gone to apply ERISA here. This conclusion is buttressed by the attention paid in *Donovan* to the entrepreneurial nature of a business:

> To be an employee welfare benefit plan . . ., an employer or employee organization, or both, *and not individual employees or entrepreneurial businesses*, must establish or maintain the plan, or program.

Id., 688 F.2d at 1373 (emphasis added). The Sixth Circuit erred in ignoring the entrepreneurial nature of petitioners' family business, which even *Donovan* would not find to have established an "employee welfare benefit plan" under ERISA.

Other courts have harmonized *Taggart* and *Donovan*. *See, e.g.*, *Clark* v. *Golden Rule Insurance Company*, 737 F.Supp. 376, 382-83 (W.D. La. 1989), *aff'd on other grounds*, 887 F.2d 1276 (9th Cir. 1989) ("[b]ecause the facts in this case are virtually indistinguishable from those in *Taggart*, the holding in *Donovan* . . . does not require a different result"). Here, the Sixth Circuit similarly could have followed *Taggart*

without doing violence to *Donovan*. But to the extent that *Taggart* and *Donovan* are in conflict, that is all the more reason to grant the petition for certiorari in the present case.

Decisions not directly on point but which illustrate the same conflict and confusion among other circuits include *Matthew 25 Ministries, Inc.* v. *Corcoran*, 771 F.2d 21, 22 (2d Cir. 1985) (group marketing service with "mixed bag group of enrollees" not covered by ERISA); *Brundage-Peterson* v. *Compcare Health Services Ins. Corp.*, 877 F.2d 509 (7th Cir. 1989) (employer's establishment of system whereby employees could choose between different insurers was an ERISA plan). Indeed, this confusion appears to exist among various panels within the same circuit. An example is the failure of the Seventh Circuit in *Brundage-Peterson* to cite or discuss the decision in *Wayne Chemical, Inc.* v. *Columbia Agency Service Corporation*, 567 F.2d 692, 699 (7th Cir. 1977), which held:

> An employer does not become a participant in, or establish or maintain, [an ERISA] plan by applying for insurance and paying premiums for what it understands to be insurance without any knowledge that the plan exists.

This conflict exists among federal courts at the district court level as well. *Compare, e.g., Plotkin* v. *Assoc. of Eye Care Centers, Inc.*, 710 F. Supp. 156 (E.D.N.C. 1989) (health insurance for employees purchased through insurance marketing association set up for small optometry employers was not subject to ERISA), *and MD Physicians & Associates, Inc.* v. *Wrotenbery*, 762 F. Supp. 695 (N.D. Tex. 1991) (following *Taggart* and finding no ERISA plan), *with Cote* v. *Durham Life Ins. Co.*, 754 F. Supp. 18, 20-21 (D. Conn. 1991) (health coverage acquired by small employer through multiple-employer trust was subject to ERISA).

The petition should be granted in order for the Court to give guidance to all the circuits and district courts on this important issue.

II.

State courts are similarly split on this issue, creating a need for Supreme Court guidance at every level.

Many state courts faced with facts similar to those presented here have followed *Taggart* or have otherwise reached the same result as was reached in *Taggart*, contrary to the result reached here. *See, e.g., Turnbow* v. *Pacific Mutual Life Ins. Co.*, 765 P.2d 1160 (Nev. 1988), *cert. denied*, 490 U.S. 1102 (1989) (liquor store's purchase of health insurance coverage for store owner and three full-time employees through multi-employer trust held not to be the establishment of an ERISA plan), *Blue Cross/Blue Shield of Florida, Inc.* v. *Weiner*, 543 So.2d 794 (Fla. Dist. Ct. App. 1989), *review denied*, 553 So.2d 1164 (Fla. 1989), *cert. denied*, 494 U.S. 1028 (1990) (service station retailer's purchase of health insurance coverage, through an independent marketing company in cooperation with the national and state service station dealer associations, held not to be an ERISA plan).

Some state courts, however, have reached a different result. *E.g., Rizzi* v. *Blue Cross of California*, 206 Cal. App. 3d 380 (1988), *cert. denied*, 493 U.S. 821 (1989). Thus the state courts deciding this threshold issue concerning ERISA's application are just as much in need of guidance from this Court as are the federal district courts and circuit courts of appeal.

Because state courts do not consider themselves bound by federal decisions other than those of the United States Supreme court (*see, e.g., Rizzo* v. *Travellers Ins. Co.*, 549 NE.2d 810 (Ill. App. 1989)), this situation adds a potential for forum-shopping to this entire dispute. If the state courts of Kentucky, for example, decide to follow *Taggart* even though the Sixth Circuit has not, plaintiffs may decide to file in federal court to seek the advantage of ERISA's attorney fees provisions or may choose state court if the potential for punitive damages seems strong. The possibility of removal

cannot stop such forum-shopping in every instance and, in fact, only encourages the defendant to do the "shopping" in cases where such removal is authorized.

The petition should be granted to resolve the same split that exists among the state courts as is found among the federal courts.

III.

The "statutory complexity" of ERISA and the "wide variety of state statutory and decisional law arguably affected by federal pre-emption" warrant the further guidance of this Court.

In *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987), this Court observed:

> Given the 'statutory complexity' of ERISA's three pre-emption provisions, . . . as well as the wide variety of state statutory and decisional law arguably affected by the federal pre-emption provisions, it is not surprising that we are again called on to interpret these provisions.

Id. at 47 (citations omitted). These same factors warrant a grant of the present petition.

The statutory complexity of ERISA continues to baffle federal and state courts, as they struggle with "tautological" definitions (*see Ft. Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, (1987)), as well as the pre-emption provisions. As the Court has observed more than once, parts of ERISA "perhaps are not a model of legislative drafting." *Pilot Life*, 481 U.S. at 46, quoting from *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985).

As to the "the wide variety" of state laws arguably affected by federal pre-emption, the present case illustrates that point well. Of 10 counts in the complaint alleging claims ranging from breach of contract to violations of Kentucky's Insurance Code, the Sixth Circuit found that only one, the count requiring substantially similar insurance coverage to be issued, survived pre-emption.[4]

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[4] The Sixth Circuit did hold, however, that some of the other counts involving state statutory claims "are enforceable in an ERISA action." 950 F.2d at 300 (appendix 10a).

This is happening all over the United States, as state laws governing issues ranging from wrongful discharge to insurance subrogation continue to disappear into "the quicksand" of ERISA. *Jordan* v. *Reliable Ins. Co.*, 694 F. Supp. 822, 835 (N.D. Ala. 1988). As one Texas Supreme Court justice recently observed:

> For the over 56 million Americans who are enrolled in group health insurance plans . . ., ERISA has become more than mere quicksand; it has become a black hole.

Cathey v. *Metropolitan Life Ins. Co.*, 805 S.W.2d 387, 392 (Tex. 1991) (Doggett, J., concurring and "join[ing] with the growing number of courts and commentators who express . . . concern [about] continued misconstruction" of ERISA).

As this Court has already explained in numerous cases, this may be for good reason in cases where compelling public policy requires that ERISA be given broad effect to avoid subjecting employers to conflicting state law. *E.g.*, *Ingersoll-Rand Co.* v. *McClendon*, 111 S. Ct. at 484. But "[t]his concern only arises . . . with respect to benefits whose provision by nature requires an ongoing administrative program to meet the *employer's* obligation." *Ft. Halifax*, 482 U.S. at 11 (emphasis added). "It is for this reason that Congress preempted state laws relating to *plans*, rather than simply to *benefits*," *Id.* (emphasis supplied by the Court). The concern is not present here, where only the insurance company's (not the employer's) obligations are invoked and where only a benefit (not a plan) has been provided.

In the recent *FMC* decision, this Court again acknowledged that its ERISA decisions sometimes result in distinctions " 'between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not'." 410 S. Ct. at 111, quoting from *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 747 (1985).

> Our interpretation . . . makes clear that *if a plan is insured, a state may regulate it* indirectly *through*

> *regulation of its insurer and its insurer's insurance contracts*; if the plan is uninsured, the state may not regulate it. As a result, *employers* will not face "conflicting or inconsistent state and local regulation of employee benefit plans."

111 S. Ct. at 411 (citations omitted) (emphasis added). Such a distinction is needed in the present context to recognize that ERISA concerns simply are not implicated by the purchase of insurance by small, entrepreneurial business.

ERISA is so complex and so broad that it presents a continuing danger that the lower courts will find it easier to deem everything pre-empted than to engage in careful analysis. Its complexity and breadth warrant this Court's further guidance to prevent this from occurring.

IV.

The Sixth Circuit's decision thwarts Congressional intent, which the Court has instructed must be the ultimate touchstone in every ERISA case, by extending the reach of ERISA to "employee benefits" even where no "employee benefit plan" exists.

This Court has recently instructed that ERISA pre-emption, "[n]otwithstanding its breadth," is not unlimited. *Ingersoll-Rand Co.* v. *McClendon*, 111 S. Ct. 478, 483 (1990). One of the limits on ERISA is that only state laws which "relate to benefit *plans* are pre-empted." *Id.* (dictum) (emphasis supplied by the Court), citing *Ft. Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 23 (1987). ERISA does not pre-empt laws relating to employee *benefits* where no plan is involved. *Id.* at 7-8. Otherwise "the word 'plan' [w]ould in effect be read out of the statute." *Id.* at 8.

> The words "benefits" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan," Congress' choice of language is significant in its pre-emption of only the latter.

Id.

The Sixth Circuit's decision in this case has extended the reach of ERISA past employee benefit plans to cover an employee benefit (*i.e.*, health insurance) even where no ERISA plan exists. Factually, nothing occurred in this case except the bare purchase of insurance by a small closely-held corporation. The employer did not undertake to determine eligibility, calculate benefit levels, make disbursements, monitor the availability of funds for benefit payments, or any of the other "administrative realities" that accompany employee benefit plans. *Id.*, 482 U.S. at 9. It just purchased insurance. As in *Ft. Halifax*, "[t]o do little more than write a

check hardly constitutes the operation of a benefit plan." 482 U.S. at 124.[5]

This case is also similar to *Ft. Halifax* in that it "fails to implicate the regulatory concerns of ERISA itself." *Id.*, 482 U.S. at 15. There are no opportunities for "self-dealing, imprudent investing, and misappropriation of plan funds" on the part of the employer. *Id.* And the insurance company's activity is already heavily regulated by state law (*unless* deemed to be pre-empted). Accordingly, such "pre-emption would in no way serve the overall purpose of ERISA." *Id.*, 482 U.S. at 16.

The Sixth Circuit's holding in the present case reaches too far and is contrary both to this Court's explanation of ERISA's purposes in *Ft. Halifax* and to Congress' stated intent:

> to protect . . . participants in *employee benefit plans* and their beneficiaries, by . . . establishing standards of conduct, responsibility, and obligation for fiduciaries of *employee benefit plans* . . . .

29 U.S.C. § 1001(b) (emphasis added). While petitioners readily acknowledge that insurance benefits can be part of an ERISA plan,[6] there is nothing in the statutory scheme that attempts to reach benefits alone, when no plan is involved.

This result is not only beyond Congressional intent, it is at cross-purposes with it. The people being hurt by decisions such as the one in this case are the very employees Congress was trying to protect. Permitting insurance companies to hide

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[5] Significantly, in *Ft. Halifax* the Court cited *Donovan*, *supra*, for this proposition and quoted its statement that "[a] decision to extend benefits is not the establishment of a plan or program." *Id.* at n.6, citing 688 F.2d at 1373. This would indicate the *Ft. Halifax* Court to read *Donovan* in a way that can be harmonized with *Taggart*, *supra*, rather than as applied by the Sixth Circuit here.

[6] This is what distinguishes *Pilot Life*, *supra*, from the present case, since in *Pilot Life* there was a "long term disability employee benefit plan". 481 U.S. at 43. Here, there is insurance but no plan.

behind ERISA thwarts, rather than furthers, the clear Congressional intent and concerns that led to ERISA in the first place.

> Through peculiar federal judicial interpretation, a statutory addition to workers' rights has been converted into a statutory removal of those rights. The law has been reshaped into a form that achieves the converse of its original purpose.

Cathey, *supra*, 805 S.W.2d at 392 (Doggett, J., concurring).

This Court has repeatedly instructed that the "purpose of Congress is the ultimate touchstone" in an ERISA case. *E.g.*, *Pilot Life*, *supra*, 481 U.S. at 45, 107 S. Ct. at 1552, *quoting Allis-Chalmers Corp.* v. *Lueck*, 471 U.S. 202, 208 (1985) (other citations omitted). This instruction bears repeating with emphasis in the present case, where Congressional intent has been not only disregarded, but severely undermined as well.

V.

The Sixth Circuit's decision carries this Court's decision in *Pilot Life* to an extreme never intended, and is contrary to Congressional intent.

As noted above, this case is distinguishable from *Pilot Life* because the threshold issue — *i.e.*, whether there there is any benefit *plan* even involved here — was not addressed in *Pilot Life*. In *Pilot Life*, this Court expressly stated that there was "no dispute that the common law causes of action asserted . . . 'relate to' an employee benefit plan . . . ." 481 U.S. at 47. The issue in *Pilot Life* was whether those state law claims were "saved from pre-emption by § 514(b)(2)(A)," 29 U.S.C. § 1144(b)(2)(A), the "saving clause" of ERISA (appendix L).

In addition to the Sixth Circuit's initial error of finding an ERISA plan where none ever existed, the Sixth Circuit further erred by carrying the *Pilot Life* decision on the "saving clause" issues in this case to an extreme never intended. The Sixth Circuit not only found the breach of contract count of the complaint to be pre-empted, but also found pre-emption of the following: (1) Kentucky cases forbidding the cancellation of an insurance policy once liability has attached; and (2) Kentucky case law forbidding illusory insurance practices.

The Sixth Circuit cited *Pilot Life* in reaching this part of its decision, but the Mississippi cases at issue in *Pilot Life* involved "only general principles of Mississippi tort and contract law." 481 U.S. at 50. Here, the Kentucky cases at issue were entirely restricted to, aimed at, and focused on insurance practices. *E.g.*, *Curry* v. *Fireman's Fund Insurance Co.*, 784 S.W.2d 176 (Ky. 1989) (forbidding illusory *insurance* practices); *Aetna Life Ins.* v. *Gullett*, 253 Ky. 544, 69 S.W.2d 1068 (1934)) (*insurance policy* cannot be cancelled once liability has attached); *Carter* v. *Aetna Life Ins. Co.*, 272 Ky. 392, 114 S.W.2d 496 (1938) (same).

The Court stated in *Pilot Life* that decisional case law, as well as statutory law, may be "saved" under ERISA. 481 U.S. at 48 n.1. The Kentucky cases relied upon here pass both the

"common sense" test and "business of insurance" test approved in *Pilot Life*. The Sixth Circuit's decision on the "saving clause" issue thus extends *Pilot Life* to find pre-emption even of state laws regulating insurance. This is contrary to the reasoning of *Pilot Life* and, again, to the expressed intent of Congress.

This Court reaffirmed the vitality of ERISA's saving clause in the recent *FMC* decision, when it directed that state laws regulating insurance (such as the laws involved here) continue in full force and are *not* pre-empted:

> An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" . . . The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

111 S. Ct. at 409. The Sixth Circuit erred in failing to recognize that New York Life "remains an insurer for purposes of state laws 'purporting to regulate insurance.' " New York Life is "not relieved from state insurance regulation." And the policy of insurance (which New York Life claims is an ERISA "plan") is bound by state insurance regulations "insofar as they apply to" New York Life.

The reasoning of the Sixth Circuit cannot be correct because its view makes the saving clause meaningless. The Court made very clear in *FMC* that a meaningless saving clause is not what either it, in its previous opinions, or Congress ever intended.

> The saving clause returns to the State the power to enforce those state laws that "regulat[e] insurance. . . ."
>
> [A law which] does not merely have an impact on the insurance industry . . . [but] is aimed at it . . . returns the matter . . . to state law.

111 S.Ct. at 407, 409. The state laws relied upon by petitioners in this case are such laws, with not merely an *impact* on the insurance industry, but *aimed* at it.

Other courts have reached a similar conclusion. In *Gahn*, *supra*, the Fifth Circuit held that Louisiana's Insurance Code prohibited Allstate from terminating insurance coverage after discovering the plaintiff had liver cancer and held that "ERISA does not preempt Mrs. Gahn's [state] statutory remedy." 926 F.2d at 1454. The court explained that because the insurance code "regulates insurance, . . . it is not superseded by ERISA." *Id.*

Similarly, *Blue Cross & Blue Shield of Alabama* v. *Lewis*, 754 F. Supp. 849 (N.D. Ala. 1991), involved what was agreed by both sides to be an ERISA plan, administered by Blue Cross. Blue Cross filed an action in the Northern District of Alabama to enforce its subrogation rights under the express terms of the policy. The insured family argued that the policy terms were forbidden and unenforceable under state law. Blue Cross argued that state was law pre-empted. The district court disagreed, based upon *FMC* v. *Holliday*:

> It is clear that *FMC*, if is stands for anything, stands for the proposition that the rights of an insurance company like Blue Cross, even though it is the fiduciary or administrator of an ERISA-governed plan, remains [sic] under the regulation of the state.
> . . .

The Sixth Circuit's decision in the present case fails to give the same credence to *FMC* and, in doing so, carries *Pilot Life* to an extreme never intended by the Court. The petition should be granted before the decision of the Sixth Circuit, already widely-cited, is adopted by other courts.

VI.

The Sixth Circuit's decision defeats both the judicial and legislative efforts of the Commonwealth of Kentucky to protect its citizens from illusory insurance practices.

As this Court has previously directed:

> ERISA pre-emption analysis "must be guided by respect for the separate spheres of governmental authority preserved in our federalist system."

Ft. Halifax, 481 U.S. at 19, quoting from *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981). Yet the Sixth Circuit's decision in the present case shows little regard for the traditional sphere of state authority in regulating insurance.

Kentucky has said it will not tolerate illusory insurance practices. It said that by judicial decision back in the 1930s when similar abuses first arose in the industry and again as recently as its December 1989 decision in *Curry*, *supra*. But the Sixth Circuit has ruled that all of those cases are pre-empted. Kentucky's legislature has passed numerous acts to protect Kentucky citizens from unfair and deceptive insurance practices. The Sixth Circuit, however, has said in this decision that all those statutes are also preempted. Kentucky has, by both statute and judicial interpretation, expressly ruled that a person harmed by the violation of a statute regulating insurance has a private cause of action. *State Farm Mutual Automobile Ins. Co.* v. *Reeder*, 763 S.W.2d 116 (Ky. 1989) (interpreting KRS 446.070). But the Sixth Circuit has said in this case that those determinations are pre-empted as well. The Sixth Circuit has effectively "overruled" most of Kentucky statutory and judicial law protecting against illusory insurance.

The *FMC* case decided by this Court directs that the federal courts be "respectful of the presumption that Congress does not intend to pre-empt areas of traditional state regulation." 111 S. Ct. at 410. Other courts have long recognized the importance of this issue in the context presented here.

E.g., *National Business Conference Employee Benefit Association* v. *Anderson*, 451 F. Supp. 458, 462 (S.D. Iowa 1977) ("court does not believe Congress intended to deprive the state of the right to protect its individual citizens from possible loss by regulating this type of insurance plan"); *Cathey*, *supra*, 805 S.W.2d at 393 (Doggett, J. concurring) ("expansive pre-emption . . . upsets the equilibrium between the federal government and the states that Congress intended to preserve by enacting the saving clause . . . , thereby eviscerating this once-important provision").

The Sixth Circuit's decision in the present case disregarded for the most part the presumption that Congress did not intend to pre-empt this area of traditional state regulation, which is the regulation of insurance. The petition should be granted to give effect to this presumption and to restore the Commonwealth's right to continue its regulation in this traditional sphere of state government.

VII.

The Sixth Circuit has decided an important question of federal law which has not been, but should be, settled by this Court.

Many of the reasons set forth above in support of this petition are overlapping, and all reflect the importance of the threshold issue, which is whether an ERISA plan is established by the mere purchase of insurance. From a practical standpoint, small businesses need to know which circuit is correct. If the Sixth Circuit's decision stands, those businesses would do their employees a favor by *not* providing health insurance coverage through work; a bonus to allow employees to purchase their own insurance independently of their employers and free of the constraints of ERISA would provide greater protection against insurance company abuses.

Also, from a practical standpoint, there is a need for the judiciary at all levels to be able to answer this question in the same way. The purchase of insurance by a small entrepreneurial business in Kentucky should not subject that employer to the burdens of ERISA and the loss of rights against an insurance company when the same act in Texas or Louisiana does not invoke ERISA at all. The Court's full appreciation of the problem may be hampered by the fact that so many decisions in this area are not officially reported. *E.g.*, *Ballay* v. *General American Life Insurance Company*, No. 89-4671 (E.D. La. August 2, 1990) (1990 U.S. Dist. LEXIS 10345); *Centennial Life Ins. Co.* v. *Robey-Barber Insurance Service Services Corp.*, No. 90-2342-V (D. Kan. July 31, 1991) (1991 WL 152819); *Prudential Ins. Co. of America* v. *Brown*, No. B14-89-00695-CV (Tex. Ct. App. August 9, 1990) (1990 WL 113682); *Sayble* v. *Blue Cross of So. California*, 208 Cal. App. 3d 1108 (1989); all contrary to the result reached in this case.

Perhaps the most important reason the Court should settle this question is to stop not only the various circuits and states from reaching conflicting decisions, but also to stop the

judiciary from acting at cross-purposes with Congress. Nearly every court that has ever had to decide one of these cases has recognized how strange it is to let insurance companies hide behind ERISA. *See, e.g., Brundage-Peterson* v. *Compcare Health Service Ins. Corp., surpa*, 877 F.2d at 512 (noting "the strangeness . . . of transforming disputes between employees and insurance contracts into suits under ERISA"). The entire concurring opinion in *Cathey*, 805 S.W.2d at 391-94, is devoted to this "paradox," "incongruous result," and "disturbing disregard for Congress' overriding intent. . . ." Some courts have blamed Congress for the incongruity, but it is the judiciary, not Congress, which has strained to reach what have become absurd results.

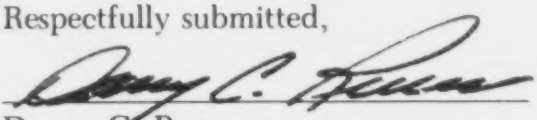
These are the kinds of rulings that make our legal system impossible to explain or defend to lay persons. Even lay persons know Congress never intended to protect insurance companies by enacting ERISA. Congress did not intend that the simple purchase of insurance be transformed somehow into the establishment of an ERISA plan. And Congress certainly never intended that all the carefully crafted state law designed to regulate insurance companies and prohibit their illusory practices, all within the traditional sphere of state regulation, be thrown out by the federal judiciary under the guise of ERISA enforcement.

This Court has never decided a *Taggart*-type case. Eleven years have passed since certiorari was denied in *Taggart* itself. These important and recurring issues have never been addressed by this Court. It is respectfully urged that the Court settle these questions by issuing the writ prayed for here.

CONCLUSION

For all these reasons, a writ of certiorari should issue to review the judgment and opinion of the Court of Appeals for the Sixth Circuit.

Respectfully submitted,



Danny C. Reeves
Counsel of Record

James G. LeMaster
Anne Adams Chesnut

GREENEBAUM DOLL &
McDONALD
333 West Vine Street, Suite 1400
Lexington, KY 40507
(606) 281-8500

Counsel for Petitioners

APPENDIX A

RECOMMENDED FOR FULL TEXT PUBLICATION
Pursuant to Sixth Circuit Rule 24

No. 91-5523/8527

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

INTERNATIONAL RESOURCES, INC.;
LARRY E. SMITH,
Plaintiffs-Appellees.

v.

NEW YORK LIFE INSURANCE COMPANY,
Defendant-Appellant.

ON APPEAL from the United District Court for the Eastern District of Kentucky

Decided and Filed November 26, 1991

Before: MARTIN and JONES, Circuit Judges; and WELLFORD, Senior Circuit Judge.

MARTIN, Circuit Judge, delivered the opinion of the court, in which JONES, Circuit Judge, joined. WELLFORD, Senior Circuit Judge (pp. 17-23), delivered a separate opinion concurring in part and dissenting in part.

BOYCE F. MARTIN, Jr., Circuit Judge. International Resources, Inc., and its president, Larry E. Smith, allege New York Life Insurance Company violated Kentucky con-

tract and tort law when the insurance company proposed cancellation of a group health insurance policy issued to the plaintiffs.

We must resolve the following questions: (1) does the Employment Retirement Income Security Act preempt all of the plaintiffs' state law claims; and (2) did the district court abuse its discretion by granting a preliminary injunction that compels New York Life to continue making payments under the disputed coverage. For the reasons given below, we affirm the district court's decision with regard to the preliminary injunction and we affirm in part and reverse in part the district court's determination that ERISA preempts the plaintiffs' state law claims. We remand this case for further proceedings not inconsistent with this opinion.

I. BACKGROUND

In 1982, International Resources purchsed group medical insurance coverage arranged by Group Marketing Services, Inc., a multi-employer trust. The insurance was administered by Group Marketing Services trust administration and underwritten by the Life Insurance Company of North America. International Resources, in its arrangement with Group Marketing Services, selected both the terms and the price for its employee coverage. All International Resources' employees were automatically covered by the plan and the company paid the insurance premiums. At the time International Resources first obtained coverage, the company had six employees; it now has two employees. On April 1, 1983, Trans Pacific Life Insurance Company succeeded the Life Insurance Company of North America as underwriter.

Larry Smith owns 75% of International Resources' stock. Smith and his dependents were insured for major medical expenses under the plan arranged by International Resources with Group Marketing Services. On May 8, 1983, Smith's son, Mark, was severely injured in an automobile accident. Mark Smith is now a mute quadriplegic and requires nursing care twenty-four hours a day.

On March 1, 1986, New York Life succeeded Trans Pacific as the underwriter for International Resources' policy. In October, 1988, New York Life announced cancellation of the group policy provided through Group Marketing Services; continuation of benefits under the policy were to cease on October 1, 1989. International Resources and Smith brought suit against New York Life in federal district court, seeking declaratory and other relief for injuries arising out of the proposed cancellation. The district court granted an injunction compelling New York Life to continue paying for Mark Smith's medical care. As part of the injunction, the court ordered International Resources to provide an escalating bond equivalent to the amount paid by New York Life for Mark Smith's treatment. Subsequently, the district court ruled that ERISA preempted all of International Resources' and Smith's state law claims.

Both New York Life and the plaintiffs first appealed this matter in December, 1990. New York Life appealed the preliminary injunction requiring it to continue providing payments under the disputed coverage. At the same time, International Resources and Smith appealed the district court determination that ERISA preempted the plaintiffs' state law claims. The 1990 appeals were heard within days of two Supreme Court decisions relevant to the parties' claims. These two cases, *FMC Corp.* v. *Holliday*, 498 U.S. ____, 111 S. Ct. 403 (1990) and *Ingersoll-Rand* v. *McClendon*, 498 U.S. ____, 111 S. Ct. 478 (1990), provide further instruction on how we should interpret ERISA's preemption provisions. Accordingly, we remanded both parties' claims to the trial court for reconsideration in light of the new case law. Upon remand, the district court reaffirmed its earlier decision giving rise to the present appeal.

II. ERISA ANALYSIS

A. *Establishment Of An ERISA Fund*

We must first determine whether International Resources established an ERISA plan. The two cases that we requested

the district court to consider upon remand, *FMC* and *Ingersoll-Rand*, do not aid us in this initial determination. Both cases, however, are helpful to our analysis of other issues and will be discussed below.

According to the statute, ERISA "plans" include:

> [A]ny plan, fund, or program, which . . . is . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

29 U.S.C. § 1002(1) (1991). We find that, "In determining whether a plan, fund or program [exists] a court must determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." *Donovan* v. *Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982), *quoted in Brown* v. *Ampco-Pittsburgh Corp.*, 876 F.2d 546, 551 (6th Cir. 1989).

The facts in *Donovan*, 688 F.2d at 1367, are similar to those now before us. In *Donovan*, small corporations and employee organizations purchased insurance from a group trust similar to Group Marketing Services. The trust, in turn, obtained the group policy from a life insurance company. The *Donovan* court determined that the companies and organizations subscribed to the trust "with the intent to provide health insurance." *Donovan*, 688 F.2d at 1374. All the parties involved in the *Donovan* trust determined the terms and conditions applicable to the trust by looking to the insurance policy and the insurer to formulate the eligibility requirements. *Id.* The participating employers and organizations required no more of the employees covered by the plan than was required by the insurer. *Id.* The *Donovan* court concluded that such employers or organizations that furnished health insurance through trusts established ERISA plans. *Id.*

International Resources and Smith attempt to rebut application of *Donovan* by relying on *Taggart Corp.* v. *Life & Health Benefits Admin., Inc.*, 617 F.2d 1208, 1211 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981). In *Taggart*, the Fifth Circuit established that "bare purchases of health insurance" that involve no owner control, administration, or responsibility for the policy or benefits, were insufficient to create an ERISA plan. Under *Taggart*, the plaintiffs argue, they did not create an ERISA plan and the *Donovan* analysis is inapplicable.

We find that the plaintiffs mistake the true relevance of *Taggart* and *Donovan* to their case. Admittedly, *Taggart* stands for the proposition that "ERISA does not regulate purchases of health insurance when there is no welfare plan." *Donovan*, 688 F.2d at 1375. However, *Taggart* does not hold that any employer who merely purchases a group health insurance policy or subscribes to a trust has not established or maintained an employee welfare benefit plan. Such a construction of *Taggart* is expressly rejected by the *Donovan* court. *Id.* We agree with the *Donovan* analysis and find that the *Donovan* court's construction of ERISA is more consistent with the Act's broad scope than *Taggart*. Employers can establish ERISA plans "rather easily." *Credit Managers Ass'n of Southern California* v. *Kennesaw Life and Accident Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987). The ERISA definition of "employee welfare benefit plan" specifically allows that ERISA plans may be established "through the purchase of insurance or otherwise." 28 U.S.C. § 1002(1); *see also*, *Brundage-Peterson* v. *Compcare Health Services Insurance Corp.*, 877 F.2d 509, 511 (7th Cir. 1989) ("barebones plan" for medical insurance coverage is "a common method by which employers provide health and other welfare benefits to their employees, and not one that has heretofore been thought to take a benefits plan out of ERISA").

Under the *Donovan* and *Brundage* analyses, International Resources has established an ERISA plan. Several of International Resources' actions are presuasive: 1) the company contracted with Group Marketing Services for the purpose of

providing insurance to its employees; 2) the company obtained the coverage for its employees; 3) the coverage was automatic and applied to all employees; and, 4) the company paid the insurance premiums. International Resources did not merely advertise alternate plans and then refrain from making any contributions on behalf of its employees. *Compare with Taggart*, 617 F.2d at 1211. Instead, International Resources chose the plan, paid the premiums, and gave this coverage to all its employees as an employee benefit. Even though Larry Smith is presently International Resources' only full-time employee, the mere fact the company no longer has several employees does not tranform what was already an ERISA plan into a non-ERISA plan. This is particularly true where there is no indication that the plan would not have been offered to another full-time employee if such were hired in the future. The combination of all these facts demonstrate that International Resources established an employee benefit plan under 29 U.S.C. § 1002(1) (1991).

B. Preemption Of State Law Claims

Because we have found an ERISA plan exists, we must now determine whether the plaintiffs' state law claims are preempted by the Act. ERISA will not preempt state law claims based on wrongs for which ERISA provides no remedy. *Perry* v. *P*I*E Nationwide, Inc.*, 872 F.2d 157, 162 (6th Cir. 1989), *cert. denied*, 110 S. Ct. 1166 (1990). However, where rights are guaranteed by ERISA, the remedy for such rights under ERISA is exclusive. *Ingersoll-Rand*, 111 S. Ct. at 485-86; *see also*, *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41, 41 (1987); *Varhola* v. *Doe*, 820 F.2d 809, 817 (6th Cir. 1987). Moreover, Congress constructed ERISA so that the statute will preempt most state law claims. *Ingersoll Rand*, 111 S. Ct. at 483; *FMC*, 111 S. Ct. at 407-408.

The Supreme Court in *FMC* discusses in detail 29 U.S.C. § 1144(a) (1991), ERISA's "pre-emption clause."[1] This clause

[1] The *FMC* Court sets forth the three ERISA provisions — commonly

provides that all state law claims which "relate to" employee benefit plans are preempted. The *FMC* Court reaffirmed that this clause "is conspicuous in its breadth." 111 S. Ct. at 407. The Court also reiterated its finding in *Shaw* v. *Delta Airlines*, 463 U.S. 85, 98 (1983), that Congress used the words "relate to" in this provision "in their broad sense." *Id.* at 408. *Ingersoll-Rand*, 111 S. Ct. at 478, demonstrates a similarly expansive reading of ERISA, and the Court's holding that the plaintiffs' state law claim was preempted by ERISA rests on anaylsis of the preemption clause. The Supreme Court in *Ingersoll-Rand* found that a claim for wrongful termination was preempted by ERISA because the inquiry for this cause of action would be dependent upon — "relate to" — the existence of an ERISA plan. *Id.* at 483. The claim was based on an allegation that the employer fired the plaintiff as a way to avoid contributing to the plaintiff's pension fund. *Ingersoll-*

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referred to as "the preemption clause," "the saving clause," and "the deemer clause" — which instruct when a state law claim is preempted:

> "Except as provided in sub-section (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." § 514(a), as set forth in 29 U.S.C. § 1144(a) (pre-emption clause).
>
> "Except as provided in sub-paragraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." § 514(b)(2)(A), as set forth in 29 U.S.C. § 1144(b)(2)(A) (saving clause).
>
> "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." § 514(b)(2)(B), as set forth in 29 U.S.C. § 1144(b)(2)(B) (deemer clause).

111 S. Ct. at 407. The holdings in both *FMC*, 111 S. Ct. at 403, and *Ingersoll-Rand*, 111 S. Ct. at 478, hinged on the Court's analysis of these three provisions and are relevant to our analysis.

Rand and *FMC* both emphasize, as well, the larger policy rationales for a broad interpretation of ERISA's preemption powers and the importance of avoiding conflicting state rules on ERISA-related matters. *Ingersoll Rand*, 111 S. Ct. at 483; *FMC*, 111 S. Ct. at 408.

The saving clause, 29 U.S.C § 1144(b)(2)(A) (1991), qualifies the preemptive force of 29 U.S.C. § 1144(a). Under the saving clause, state laws regulating insurance are not preempted by ERISA when they are "saved" by the express terms of this provision. *FMC*, 111 S. Ct. at 407. The saving clause "returns to the States the power to enforce those state laws that 'regulate insurance' *except as provided in the deemer clause.*" *Id.* at 408. The deemer clause, § 1144(b)(2)(B) thus qualifies the qualification made in the saving clause by requiring that "an employee benefit plan governed by ERISA shall not be 'deemed' an insurance company, an insurer, or engaged in business of insurance for the purposes of state laws purporting to regulate insurance companies or insurance contracts." *Id.* at 407. Analysis of the "deemer clause" was the root of the Supreme Court decision in *FMC*. There, the Court concluded that ERISA, through its deemer clause, preempted a Pennsylvania anti-subrogation statute. 111 S. Ct. at 403.

International Resources and Smith argue that four of their state law claims are not preempted but rather are saved by the saving clause. Following our remand of the issues raised by the first set of appeals, the district court rejected this argument by the plaintiffs and dismissed all of their state law claims. The court, which did not address the merits of each of the four claims individually, simply held that all the plaintiffs' state law claims were preempted "because they relate to the administration of an employee welfare benefit plan." After applying the latest Supreme Court analysis on the subject of preemption, we find that at least one of International Resources' claims has merit and is not preempted by ERISA. Thus, we partially reverse the district court determination.

International Resources' first claim is that Kentucky law, which forbids the cancellation of an insurance policy once

liability has attached, is not preempted by ERISA. In support of this claim, International Resources cites to *Aetna Life Ins.* v. *Gullett*, 253 Ky. 544 (1934), and *Carter* v. *Aetna Life Ins. Co.*, 272 Ky. 392 (1938). These cases, however, are based on the common law of contracts as applied to agreements to provide insurance. Because the Kentucky law relied upon merely states a rule of general applicability, rather than a rule specifically directed toward the insurance industry and to insurance policy matters, International Resources' first state law claim is not rescued by the savings clause. *See Pilot Life*, 481 U.S. at 50-51. In *McMahan* v. *New England Mutual Life Insurance Co.*, 888 F.2d 426 (6th Cir. 1989) we articulated the test for determining when the saving clause applies:

> [W]e must consider whether the applicable state law: (1) has the effect of tranferring or spreading policyholders' risk; (2) constitutes an integral part of the policy relationship between the insurer and the insured; and (3) is limited to entities within the insurance industry.

Id. at 429. Under this test, which does not conflict with either *FMC* or *Ingersoll-Rand*, International Resources' first state law claim cannot survive.

Second, International Resources suggests that its claim for the tort of bad faith in insurance practice survives under the saving clause. International Resources relies upon *Curry* v. *Fireman's Fund Insurance Co.*, 784 S.W.2d 176 (Ky. 1989), which limits recognition of this cause of action to the tort of illusory insurance practices. Despite the *Curry* court's restriction of this tort to insurance cases, this tort is not directed to the insurance industry any more than it is directed to the law of contracts generally. The Supreme Court has taken a narrow view of the factors that shall be deemed "integral" to insurance law, finding that the law in question must affect specific terms of the insurance policy. *See Pilot Life*, 481 U.S. at 50-51; *see also*, *McMahan*, 888 F.2d at 426. According to the *Pilot Life* Court:

> Certainly a common-sense understanding of the phrase 'regulates insurance' does not support the argument that the Mississippi law of bad faith falls under the saving clause . . . Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law.

Id. at 50. Thus, International Resources' state law claim under *Curry* is preempted and not saved by the saving clause.

International Resources attempts a third state law claim based on Kentucky insurance code provisions that prohibit unfair and deceptive practices in the insurance business. *See* Ky. Rev. Stat. § 304.12-010, 020. The remedy for violation of these laws is created by Ky. Rev. Stat. § 446.070, which is a law of general applicability. *See State Farm Mutual Auto Insurance Co.* v. *Reeder*, 763 S.W.2d 116 (Ky. 1988). These statutes are enforceable in an ERISA action, *see, e.g.*, *Ruble v. UNUM Life Insurance Company of America*, 913 F.2d 295, 297 (6th Cir. 1990) ("nothing in ERISA would prevent the insurance policy from being enforced in its statutorily modified form"). Because, then, the remedy is one of general applicability and conflicts with § 1132 of ERISA, it must be superceded by the remedy provided under the Act.

International Resources' fourth and final state law claim, that the conversion policy issued by New York Life did not conform with Ky. Rev. Stat. § 304.18-110(5), has merit and survives preemption. This Kentucky statute requires that substantially similar policies be issued by successor insurers. *Id.* As our preceding analysis demonstrates, most state law claims are not "saved" by the saving clause because such claims do no reflect statutory or common law rules that are specifically aimed at regulating the insurance industry. Here, however, and in contrast to the district court, we find the conversion statute qualifies as a state law specifically aimed at regulating the insurance industry and so is not preempted. Our determination is based upon a common-sense under-

standing of the phrase "regulates insurance," *see McMahan*, 888 F.2d at 429, and by our belief that this statute meets the three-prong test of *McMahan*, described *supra*. We note as well that, as a general rule, state insurance law applies to insurance policies purchased by ERISA plans. *Michigan United Food & Commercial Workers Unions* v. *Baewaldt*, 767 F.2d 308, 313 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986).

Several key Supreme Court cases influence our determination that International Resources' fourth claim survives ERISA preemption. In *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 735 n. 14 (1985), the Court found that a Massachusetts "mandated benefit law" — whereby insurers were required to provide specific medical benefits whenever a Massachusetts resident purchased a certain form of insurance — survived preemption under ERISA. The *Pilot Life* Court, 481 U.S. at 41, made express reference to *Metropolitan Life*, seemingly greatly limiting the degree to which state law claims may be deemed to have survived ERISA preemption under the saving clause. The *Pilot Life* Court held that § 1132 of ERISA — the remedies provision — provides the "exclusive vehicle for actions" if a court construes Congress intended ERISA to apply. *Id.* The *Pilot Life* Court's reading of § 1132 as a broad preemption remedial provision is based upon Congress's explicit remarks that § 1132 was intended to be analagous to the National Labor Relations Act's broadly preemptive remedies provision. *Id.*

Admittedly, the Kentucky conversion statute does not qualify as a "mandated benefit law." Nonetheless, we find the principles of *Metropolitan Life*, as well as other Supreme Court cases, are applicable and that the plaintiffs' conversion claim survives preemption in spite of *Pilot Life*. The recent decision of *Ingersoll-Rand* directly bears upon this understanding of *Pilot Life*. In *Ingersoll-Rand*, 111 S. Ct. at 485, the Court found that the plaintiff's state law claim conflicted with 29 U.S.C. § 1140 because this provision was directed at employers who would otherwise "circumvent the provision of promised benefits." The *Ingersoll-Rand* Court addressed the potentially conflicting analyses of *Pilot Life* and *Metropolitan*

Life and found that the *Pilot Life* analysis of 502 (a) showed "Congress intended 502(a) to be the exclusive remedy for *rights guaranteed under ERISA.*" *Ingersoll-Rand*, 111 S. Ct. at 485 (emphasis added). Thus, because we cannot fairly assume the activity Kentucky is regulating through its conversion statute is protected or guaranteed by an ERISA remedy, the *Pilot Life* analysis is inapplicable and the Kentucky statute survives preemption. *See id.*

This determination is further buttressed by *FMC*. There, the Court considered the effect the deemer clause may have on state law claims. The *FMC* Court found that "the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans." *Id.* at 411. The Court then observed:

> We have identified laws governing the "business of insurance" in the Act to include not only direct regulation of the insurer but also regulation of the substantive terms of insurance contract . . . [citation omitted]. By recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the States the regulation of the "business of insurance."

Id. at 410. By distinguishing between insured and uninsured plans, leaving the former open to indirect regulation though not the latter, the *FMC* Court indicates that an insurance company such as New York Life, that insures a welfare benefit plan like that purchased by International Resources, "remains an insurer for purposes of state laws purporting to regulate insurance after application of the deemer clause." *FMC*, 111 S. Ct. at 409. The *FMC* Court's analysis not only enhances our understanding of what the phrase "regulates insurance" means, the Court clarifies that plans such as the one

at issue here do not fail under deemer clause analysis. Because the standards we announced in *McMahan*, 888 F.2d at 426, are not abrogated by current Supreme Court analysis, we find that plaintiffs' claim under the Kentucky conversion statute survives preemption by ERISA.

C. Vesting Of Welfare Benefits

Finally, we come to a matter not addressed by the district court though raised by the parties on appeal. That is, whether or not the plaintiffs' rights have "vested" for the purpose of bringing the instant claims. We have held that pension plans are subject to statutory vesting requirements under 29 U.S.C. § 1053, although welfare plans are not. *Armistead* v. *Venitron*, slip op. 89-6405, at 18 (6th Cir. Sept. 24, 1991). New York Life would have us believe that a welfare plan will *never* vest, because there is no statutory vesting requirement, or that such a welfare plan can only vest if it has explicit provisions providing for vesting in the plan documents. New York Life, however, misstates the law of *In re White Farm Equipment Co.*, 788 F.2d 1186, 1193 (6th Cir. 1986). There, we found that we will not construe ERISA as providing a *mandatory point* for welfare benefits to vest. Nonetheless, a court may look to the parties' intent to determine when vesting should occur. Such intent may be demonstrated by "agreement or by private design." *Id. See also*, *Armistead*, slip. op. 89-6405, at 18. There may be sufficient evidence for the district court to find plaintiffs' claims have vested. However, because this point was not addressed by the district court and because we feel that it merits further development, we direct that this issue by considered upon remand.

III. PRELIMINARY INJUNCTION

We must also determine whether the preliminary injunction should continue against New York Life. Our determination requires consideration of: (1) the likelihood of success on

the merits; (2) whether irreparable injury will result without the injunction; (3) the probability of substantial harm to others; and (4) whether the public interest is advanced by the injunction. *See Christian Schmidt Brewing Co.* v. *G. Heileman Brewing Co.*, 753 F.2d 1354, 1356 (6th Cir.), *cert. dismissed*, 469 U.S. 1200 (1985). Our review is limited to a determination of whether the district court abused its discretion. *Tate* v. *Frey*, 735 F.2d 986, 990 (6th Cir. 1984).

The trial court's grant of injunction was based on a finding of "substantial likelihood of success on the merits from within the four corners of the insurance contract, notwithstanding application of ERISA." The court's finding derived from several factors: 1) the contract of insurance guaranteed lifetime benefits of up to $1,000,000 of which only about half had been distributed by the time of the lawsuit; 2) the New York Life certificate stated that "if a person is totally disabled when coverage ends, benefits may continue for covered expenses due to the condition which caused the disability;" and, 3) the New York Life policy stated that it would continue benefits under which Mark Smith had been receiving payments and that "an Individual's insurance with respect to [a] dependent child shall not terminate as long as the Individual's insurance remains in force and as long as [the dependent's physical] incapacity continues." Although New York Life alleges the district court's findings are erroneous, our review reveals no abuse of the court's discretion and that it acted reasonably.

The district court properly examined the remaining factors necessary for a grant of preliminary injunction. The court considered the irreparability of injury to the parties, the potential for harm to others, and the broader policy implications, should it impose the injunction. The court's determination regarding these issues was influenced by several factors: 1) the loss of the funds would adversely affect the proper maintenance of Mark Smith's health; 2) the litigation was making the retention of qualified medical caretakers difficult; 3) interruption of the care might cause irreversible physical harm to Mark Smith; 4) a bond posted by the plaintiff would

protect New York Life's financial outlay; and 5) only the parties to this litigation are at risk of any substantial harm.

The district court's determination that there was a likelihood of substantial harm due to interrupted care is a factual finding that we will not disturb unless clearly erroneous. *United States* v. *United States Gypsum Co.*, 333 U.S. 364, 394 (1948). Contrary to New York Life's assertions, the district court's finding that Smith was having difficulty attracting medical care was supported by evidence in the form of Smith's affidavit and thus is not clearly erroneous. There are no significant public policy concerns weighing against the injunction; in fact, public policy weighs in favor of an injunction. The factors relied upon by the district court remain unaffected by our determination that the bulk of plaintiffs' claims are governed by ERISA, although one state law claim may survive. Accordingly, we find there was no abuse of discretion by the district court and the grant of preliminary injunction is upheld.

For the foregoing reasons, the determination of the district court with regard to the preliminary injunction is affirmed. The district court's judgment regarding the preclusion of state law claims is affirmed in part and reversed in part. This matter is remanded to the trial court for further proceedings not inconsistent with this opinion.

WELLFORD, Senior Circuit Judge, concurring in part and dissenting in part:

I concur in parts I and IIA of Judge Martin's opinion. I also concur in that portion of part IIB that concludes that ERISA pre-empts three of plaintiffs' state law claims.[1]

I dissent, however, from the conclusion in part IIB that the fourth state claim, "that the conversion policy issued by New

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[1] Judge Martin states that ERISA pre-empts: 1) the claim that cancellation of the policy is forbidden "once liability has attached;" 2) "the tort of bad faith in insurance practice;" and 3) the claim of "unfair and deceptive practices in the insurance business."

York Life did not conform with [Ky. Rev. Stat.] § 304.18-110(5), has merit and survives pre-emption." This segment of the opinion reverses the district court's decision after a prior remand in which we stated, "*While not disagreeing* with the district court's judgment, we remand . . . so that the district court may consider . . . this case in light of *FMC Corp.* v. *Holliday*, [111 S. Ct. 403] (1990), and *Ingersoll-Rand* v. *McClendon*, 111 S. Ct. [478] (1990)." (Emphasis added). The district court found nothing compelling in either recent Supreme Court decision to change its pre-emption decision. I continue to agree, and I would affirm the defendant's judgment.

The Supreme Court has indicated that "[ERISA's] 'carefully integrated' civil enforcement scheme . . . 'is one of the essential tools for accomplishing the stated purposes of ERISA.' " *Ingersoll-Rand*, 111 S. Ct. at 482, *quoting Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 52 (1987).[2] As stated by the majority, "where rights are guaranteed by ERISA, the remedy for such rights under ERISA is exclusive." This is not to say, however, that enforcement of rights under "a comprehensive statute such as ERISA" need to be as extensive or encompassing as a pre-empted state remedy. *Ingersoll-Rand*, 111 S. Ct. at 482; *see Pilot Life*, 481 U.S. at 53-54 (indicating that ERISA pre-empts a state claim for improper processing even though ERISA, unlike the state claim, does not allow punitive damages).

> Under the civil enforcement provisions of § 502(a) [29 U.S.C. § 1132(a)], a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment

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[2] Justice O'Connor was the author of *FMC Corp.*, *Ingersoll-Rand*, and *Pilot Life*, the latter holding that state laws on tortious breach of contract and "bad faith" of the insurance carrier, which allowed punitive damages, were pre-empted.

> on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty, and under this cause of action may seek removal of the fiduciary. §§ 502(a)(2), 409. In an action under these civil enforcement provisions, the court in its discretion may allow an award of attorney's fees to either party.

Pilot Life, 481 U.S. at 53.

Thus the *Pilot Life* court implied that although ERISA did not provide for punitive damages, ERISA pre-empted the plaintiffs' more beneficial state law claims. The *Ingersoll-Rand* opinion cites *Pilot Life* no less than five times in holding that a Texas wrongful discharge action would not lie even if the claimed reason for discharge was the "employer's desire to avoid contributing to or paying benefits under the employee's pension fund." *Ingersoll-Rand*, 111 S. Ct. at 479 (Syllabus).

In this case, plaintiffs may sue under ERISA for "accrued benefits due," "to enforce [Smith's] rights under the plan," "for an injunction [for] improper refusal to pay benefits," and "for breach of fiduciary duty" as set out in *Pilot Life*. If successful under ERISA on their wrongful termination of insurance benefits and "improper refusal to pay" claims, then plaintiffs have no need to seek what seem to me to be unclear "conversion" rights under Ky. Rev. Stat. § 304.18-110(5) which the majority holds are not pre-empted:

> The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if (a) such person is covered for similar benefits by another hospital or surgical or medical expense insurance policy or hospital or medical service

> subscriber contract or medical practice or other prepayment plan or by any other plan or program of (b) similar benefits are provided for, or available to, such person pursuant to, or in accordance with the requirements of, any statute, and the benefits provided or available under any of the sources referred to in (a) and (b) above for such person, together with the converted policy, would result in over insurance according to the insurer's standards relating to policies converted from group policies. A converted policy made available pursuant hereto shall provide substantially similar benefits but in no event be less than the minimum standards contained in KRS 304.18-120 if delivery of such converted policy is to be made in this state; and if delivery of such converted policy is to be made elsewhere, it may be on such form as the insurer may then be offering for such conversion in the jurisdiction where such delivery is to be made and which provides substantially in compliance with that required by KRS 304.18-120.

Ky. Rev. Stat. § 304.18-110(5).[3]

The majority indicates that because they "cannot fairly assume" that ERISA provides the plaintiffs with a similar remedy, then the claimed conversion rights are not preempted. Plaintiffs cite, as a basis for this argument, *Perry* v.

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[3] Ky. Rev. Stat. § 304.18-1103(3) provides for conversion of a group "hospital or surgical benefits" policy "if coverage terminates for any reason." Whether Mark Smith's policy came within the meaning of the Kentucky statute is unclear. It is likewise unclear whether he is "covered by Medicare" or may have "similar benefits" under another policy or policies. The cost of an individual "converted" policy to provide substantially similar benefits to Mark Smith is covered by the terminated group policy is also unknown. Plaintiffs' supplemental brief at p. 18, refers to a "conversion policy offered [which] did not provide for 24-hour private duty nursing care at home." Defendant apparently offered a conversion policy, but plaintiffs question whether it provided substantially similar benefits to the group insurance coverage.

*P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989). *Perry*, however, involved fraud in the inducement in "obtaining participation" in the plan. *Id.* at 158. If the claim in *Perry* were pre-empted, then the plaintiff would not have been able to prove fraud and no plan would have existed justifying, among other things, drastic pay cuts despite preexisting collectively-bargained rates of pay. *Perry* is not analogous to this case where a plan, unchallenged for many years, was carried out to plaintiff's great benefit and the issue relates to a right to terminate. Another case relied on by the majority, *Michigan United Food & Commercial Workers Unions* v. *Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986), simply held, pursuant to *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985), that Michigan's similar "mandated benefit law" was not pre-empted. The majority concedes that Ky. Rev. Stat. § 304.18-110(5) "does not qualify as a 'mandated benefit law'." I find no basis, therefore, to conclude that *Metropolitan Life* mandates "that the plaintiff's conversion claim survives pre-emption in spite of *Pilot Life*." *Ingersoll-Rand* fully supported the rationale of *Pilot Life*.

Nor is the majority's reasoning somehow buttressed by *FMC Corp.* Plaintiffs' counsel conceded in a December 14, 1990 letter to the court, "because the employer in *FMC* was *self*-insured, the case did not involve any purchase or regulation of insurance and the result in that case instead turned on ERISA's 'deemer' clause, which all parties recognize is inapplicable here." (Emphasis in original). *FMC* holds that "[t]he pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *Id.* at 407. That language is quoted in *Ingersoll-Rand*. *See Ingersoll-Rand*, 111 S. Ct. at 482. *FMC* held only that the "deemer clause" exempts "self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause." *FMC*, 111 S. Ct. at 409.

Under *McMahan* v. *New England Mut. Life Ins. Co.*, 888

F.2d 426 (6th Cir. 1989), it is a close question whether Ky. Rev. Stat. § 304.18-110(5), unlike the Kentucky law involved in that case, is a law which "regulates insurance within the meaning of ERISA's saving clause," *id.* at 430, but I would conclude that *McMahan* is not a basis for avoiding ERISA pre-emption of this claim.

I would hold that plaintiffs must proceed on the basis of an ERISA claim to enforce their asserted rights under the policy for the alleged improper refusal to pay and for wrongful termination. I cannot conclude or assume that ERISA provides no potential remedy to plaintffs on their claim that New York Life failed to make benefit payments under the policy. That ERISA may provide to plaintiffs a lesser remedy than state law, is not a basis to deny pre-emption. Even if the district court were ultimately to decide that the plaintiffs do not have an ERISA claim under the circumstances, that would also not be a basis to allow plaintiffs to proceed on a pre-empted state law claim merely because "we cannot fairly assume the activity Kentucky is regulating through its conversion statute is protected . . . by an ERISA remedy."[4] In fact, it appears that New York Life offered plaintiffs a conversion right to a private policy upon termination of the group major medical policy.

In any event, it is clear that plaintiffs cannot claim punitive damages in this case. This is quintessentially a contract case. To the extent vesting of benefits in this dispute must be decided, I would remand that issue to the district court with directions to determine the parties' intentions in light of the policy language, status of the plaintiffs, commitments made to continue benefits, if any, and the actions of the parties. The district court should consider *Armistead* v. *Venitron*, ____ F.2d ____, Slip op. 89-6405/06 (6th Cir. Sept. 24, 1991); *Anderson* v. *Alpha Portland Indus., Inc.*, 836 F.2d 1512 (8th Cir. 1988), *cert. denied*, 489 U.S. 1051 (1989); *In re White*

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[4] The plan has provided a New York Life major medical reimbursement policy. It is unclear whether the Kentucky statute relied upon by plaintiffs, and by the majority, applies to such a policy.

Farm Equip. Co., 788 F.2d 1186 (6th Cir. 1986); *Implement Workers* v. *Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983), *cert. denied*, 465 U.S. 1007 (1984).

> ERISA divides benefit plans into two classes: "welfare benefit plans" and "pension plans." *See* 29 U.S.C. §§ 1002(1) & (2)(A). The group insurance plan in *White Farm* and the one at issue here are welfare benefits plans. *White Farm*, 788 F.2d at 1187; *Musto* v. *American General Corp.*, 861 F.2d 897, 901 n.2 (6th Cir. 1988). Pension plans are subject to statutory vesting requirements, 29 U.S.C. § 1053, but welfare plans are not. The question the *White Farm* court decided was whether welfare benefits had vested at retirement as a matter of federal common law under ERISA.

Venitron, slip op. at 9.

On the question of the preliminary injunction discussed in part III, I agree that the injunction should continue, but, on remand to the district court, both parties should have the opportunity for a prompt hearing to determine, in light of *present* circumstances, whether: (1) "loss of [insurance] funds would adversely affect" Mark Smith's care; (2) litigation makes "retention of qualified medical caretakers difficult;" (3) other resources for health care are available; and (4) there might be some interruption in necessary care, and, if so, the effect on Mark Smith.

In summary, I concur in the conclusion that this case concerns an ERISA plan and that three of the four stated state law claims are pre-empted. I dissent in respect to the fourth, so-called Kentucky "conversion" right claim, because I conclude it is also pre-empted.

I concur in the remand for a determination, if necessary, whether Smith's rights under the plan were "vested." I would also remand for another prompt hearing on the propriety of the preliminary injunction.

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No: 91-5523: 91-8527 Civil 90-32

INTERNATIONAL RESOURCES, INC.;
LARRY E. SMITH;
Plaintiffs-Appellees,

v.

NEW YORK LIFE INSURANCE COMPANY,
Defendant-Appellant.

Before: Martin and Jones, Circuit Judges; Wellford, Senior Circuit Judge

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JUDGMENT
(Filed November 26, 1991)

ON APPEAL from the United States District Court for the Eastern District of Kentucky at Pikeville.

THIS CAUSE was heard on the record from the district court and was argued by counsel.

ON CONSIDERATION WHEREOF, it is ordered that the judgment of the district court with regard to the preliminary injunction is affirmed; the judgment regarding the preclusion of state law claims is affirmed in part and reversed in part. The case is remanded for further proceedings not inconsistent with the opinion.

Entered By Order Of The Court
/s/ LEONARD GREEN,
Clerk

A True Copy.

Attest:
/s/ Diane Schnur
Deputy Clerk

APPENDIX B

Nos. 91-5523/91-8527

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

INTERNATIONAL RESOURCES, INC.; LARRY SMITH;
Plaintiffs-Appellees, (91-5523),
Petitioners (91-8527),

v.

NEW YORK LIFE INSURANCE COMPANY,
Defendant-Appellant. (91-5523),
Respondent (91-8527)

BEFORE: MARTIN and JONES, Circuit Judges; WELLFORD, Senior Circuit Judge

ORDER

(Filed January 15, 1992)

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

Entered By Order Of The Court

/s/ LEONARD GREEN
Clerk

APPENDIX C

Nos. 91-5523/91-8527

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

INTERNATIONAL RESOURCES, INC.;
LARRY E. SMITH;
Petitioners (91-8527),
Plaintiffs-Appellees, (91-5523),

v.

NEW YORK LIFE INSURANCE COMPANY,
Respondent (91-8527)
Defendant-Appellant. (91-5523),

BEFORE: MARTIN and JONES, Circuit Judges; WELLFORD, Senior Circuit Judge

ORDER
(Filed July 8, 1991)

The plaintiffs seek permission to appeal, pursuant to 28 U.S.C. § 1292(b), the district court's decision entered upon remand from this court. (Case No. 91-8527). The defendant appeals the injunction entered by the district court. (Case No. 91-5523). The parties jointly move to consolidate these cases and to adopt the briefs previously filed in the prior appeals before this court.

Upon consideration, it is **ORDERED** that Case No. 91-5523 and the petition in Case No. 91-8527 are consolidated. The motion to adopt the prior briefs and joint appendix is granted. Additionally, the following schedule for any supplemental briefing, including briefing on the merits of the petition pending in Case No. 91-8527, is adopted:

Defendant-Appellant/Respondent's brief due: August 8, 1991.

Plaintiffs-Appellees/Petitioner's brief due: September 9, 1991.

Defendant-Appellant/Respondent's reply brief and supplemental joint appendix due: September 18, 1991.

Oral argument on all pending matters in these consolidated cases shall be on September 24, 1991, at 9:00 a.m.

ENTERED BY ORDER OF THE COURT

/s/ LEONARD GREEN,
Clerk

APPENDIX D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
PIKEVILLE DIVISION

CIVIL ACTION NO. 90-32

INTERNATIONAL RESOURCES, INC.;
and LARRY E. SMITH;
PLAINTIFFS,

v.

NEW YORK LIFE INSURANCE COMPANY,
DEFENDANTS,

MEMORANDUM OPINION AND ORDER
(Filed March 28, 1991)

This diversity action is before the Court on remand from the Sixth Circuit Court of Appeals to consider for the first time the facts of the present case in light of *FMC Corp.* v. *Holliday*, ____ U.S. ____, 111 S.Ct. 403 (1990), and *Ingersoll-Rand* v. *McClendon*, 498 U.S. ____, 111 S.Ct. 478 (1990). [Record No. 94]. Fully briefed and argued, the matter is ripe for decision.

INTRODUCTION

This case presents two issues for the Court's consideration. First, the court must consider whether the order granting summary judgment in favor of the defendant was appropriate in light of new and relevant case law. Second, is an inquiry into whether the court should reconsider the propriety of its injunctive order requiring the defendant to continue paying benefits while this action is pending, even if ERISA applies.

[Record No. 72]. Based upon the memoranda submitted by the parties and oral arguments heard on these matters, summary judgment is appropriate in the defendant's favor, and the preliminary injunction shall remain in effect.

PROCEDURAL HISTORY

The plaintiffs, International Resources, Inc. [International], and Larry Smith [Smith], brought this action alleging violations of Kentucy contract and tort law by the defendant, New York Life Insurance [NYL], stemming from its attempt to cancel coverage under a group health insurance policy issued to Smith. On March 5, 1990, the court entered a preliminary injunction requiring the defendant to continue paying medical expenses of Paul Markham Smith and, in addition, requiring the plaintiffs to post a bond equal to the funds expended by the defendant. [Record No. 34]. On August 6, 1990, the court entered an order granting summary judgment in favor of the defendant, finding that the plaintiffs' state law causes of action in contract and tort were preempted by the Employee Retirement Income Security Act of 1974 [ERISA], 29 U.S.C. § 1001 *et seq.* [Record No. 59]. Upon interlocutory appeal of the court's summary judgment ruling, the Sixth Circuit, while not disagreeing with the court's judgment, remanded this case for consideration of the facts in light of *FMC Corp.* v. *Holliday*, ____ U.S. ____, 111 S.Ct. 403 (1990), and *Ingersoll-Rand* v. *McClendon*, 498 U.S. ____, 111 S.Ct. 478 (1990). [Record No. 94].

STATEMENT OF FACTS

For the sake of brevity, the court will refrain from recounting the relevant facts in their entirety, but will simply refer to them as recited in the previous memorandum opinion and order entered on August 6, 1990. [Record No. 59].

DISCUSSION

As a preliminary matter, the court will refrain from a detailed analysis of why the group insurance plan in the pres-

ent action is an employee welfare benefit plan within the terms of ERISA. Instead, the court will simply refer to its analysis as stated in the previous order of August 6, 1990, as the still applicable rationale for this finding. Neither *FMC* nor *Ingersoll-Rand* dictates finding to the contrary, and the court will now choose to focus its attention on the issue of whether the plaintiff's state law claims are pre-empted under ERISA.

Three clauses of ERISA bear distinct applicability to the facts of the present case: the preemption clause, the saving clause and the deemer clause. The Supreme Court, in *FMC*, clearly explained the relationship of the three by stating that:

> We indicated in *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), that these provisions are not a model of legislative drafting.' (citations omitted). Their operation is nevertheless discernible. The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that 'regulat[e] insurance,' except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be 'deemed' an insurance company, an insurer, or engaged in the business of insurance for the purposes of state laws 'purporting to regulate' insurance companies or insurance contracts.

FMC, 111 S.Ct. at 407.

As discussed above, ERISA pre-empts any state law that "relates to" an employee welfare benefit plan governed by ERISA. *FMC*, 111 S.Ct. at 407. "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection or reference to such a plan." *Cathey* v. *Metropolitan Life Ins. Co.*, No. C-8323, slip op. at 5-6 (Texas

Supreme Court Jan. 30, 1991) (citing *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983)). The language "relates to" was construed rather broadly in *Ingersoll-Rand* to include a cause of action for wrongful termination where it was based on the allegations that the employer fired the employee to avoid paying benefits under a pension plan. *Ingersoll-Rand Co.* v. *McClendon*, 111 S.Ct. 478 (1990).

In the present case, the plaintiffs brought this action asserting violations of Kentucky contract and tort law in the administration of funds under Smith's employee benefit plan. Thus, the plaintiffs' causes of action "relate to" an employee benefit plan governed by ERISA and are subject to pre-emption. *See FMC*, 111 S.Ct. at 407. This finding is warranted regardless of the saving clause of ERISA, which in other cases allows the state of Kentucky to retain authority over the state law claims.

In *FMC* the Supreme Court clearly discussed both the saving clause and the deemer claim, teaching that a party might avoid pre-emption of state law claims. In that case the Supreme Court stated that:

> We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause. By forbidding States to deem employee benefit plans 'to be an insurance company or other insurer . . . or to be engaged in the business of insurance,' the deemer clause relieves plans from state laws 'purporting to regulate insurance.' As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation 'relates to' the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not 'saved' because they do not regulate insurance. State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

FMC, 111 S.Ct. at 409.

Although the present case does not involve a self-funded insurance plan, the language of *FMC* still applies. The state law claims brought by the plaintiffs are pre-empted because they relate to the administration of an employee welfare benefit plan. Because the deemer clause specifies that such a plan cannot be considered insurance, the state law claims are not saved since they do not regulate an insurance plan as described in *FMC*.

Thus, based on the law as discussed in *FMC* and *Ingersoll-Rand*, the court concludes that the defendant is entitled to summary judgment in this matter.

CONCLUSION

Having considered the record in light of the "new era" criteria applicable to summary judgment, *see Street* v. *J.C. Bradford and Company*, 886 F.2d 1472 (6th Cir. 1989); *Darnell* v. *Campbell County Fiscal Court*, 731 F. Supp. 1309, 1311-12 (E.D. Ky. 1990), the court concludes that the defendant is entitled to summary judgment on the issue of pre-emption of the state law claims.

Accordingly, IT IS ORDERED:

(1) That the defendant's motion for summary judgment be, and the same hereby is, GRANTED.

(2) That the plaintiffs shall be granted until April 29, 1991, to file an amended complaint.

(3) That the preliminary injunction previously entered in this action will remain in effect pending resolution of this action.

This the 27th day of March, 1991.

/s/ JOSEPH M. HOOD,
JUDGE

Date of Entry and Service: Mar. 28, 1991

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
PIKEVILLE DIVISION

Civil Action No. 90-32
Judge Joseph M. Hood

INTERNATIONAL RESOURCES, INC.;
and LARRY E. SMITH;

Plaintiffs

v.

NEW YORK LIFE INSURANCE COMPANY,

Defendant.

ORDER
(Filed May 7, 1991)

Upon motion of the Plaintiffs and the court being sufficiently advised, it is hereby

ORDERED that the Memorandum Opinion and Order entered herein on March 28, 1991, be and is hereby amended to include the following additional paragraph:

> This Order involves controlling questions of law as to which there is substantial ground for difference of opinion, and an immediate appeal from this Order may materially advance the ultimate termination of the litigation. This determination is made pursuant to 28 U.S.C. § 1292 (b) to permit application for an immediate interlocutory appeal from this Order.

Entered this 7th day of May, 1991.

/s/ JOSEPH M. HOOD
JUDGE, UNITED STATES
DISTRICT COURT

APPENDIX E

NOT RECOMMENDED FOR FULL-TEXT PUBLICATION

Sixth Circuit Rule 24 limits citation to specific situations. Please see Rule 24 before citing in a proceeding in a court in the Sixth Circuit. If cited, a copy must be served on other parties and the Court.
This notice is to be *prominently* displayed if this decision is reproduced.

Nos. 90-5434, 90-6411

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

INTERNATIONAL RESOURCES, INC.;
LARRY E. SMITH,
Plaintiffs-Appellees,

v.

NEW YORK LIFE INSURANCE COMPANY,
Defendant-Appellant.

Before: MARTIN, JONES, and WELLFORD, Circuit Judge

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF KENTUCKY
(Filed January 22, 1991)

PER CURIAM. While not disagreeing with the district court's judgment, we remand this case so that the district court may consider for the first time the facts of this case in light of *FMC Corp.* v. *Holliday*, 110 S. Ct. 2203 (1990), and

Ingersoll-Rand v. *McClendon*, 498 U.S. ____. 111 S. Ct. 32 (1990).

Pending that resolution the temporary injunction entered by the district court shall remain in effect.

APPENDIX F

Nos. 90-5434 90-8562

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

INTERNATIONAL RESOURCES, INC.;
LARRY E. SMITH;
Plaintiffs-Appellees,

v.

NEW YORK LIFE INSURANCE COMPANY,
Defendant-Appellant.

INTERNATIONAL RESOURCES, INC.;
LARRY E. SMITH
Plaintiffs-Petitioners

v.

NEW YORK LIFE INSURANCE COMPANY
Defendant-Respondent

ORDER

(Filed November 9, 1990)

Upon consideration of the plaintiffs' motions to consolidate the above-styled actions, to expedite their interlocutory appeal and for leave to file supplemental briefs.

It is therefore **ORDERED** that the petition for permission to appeal be, and it hereby is, granted.

It is further ORDERED that the remaining relief being sought be, and it hereby is, granted. The parties are directed to file supplemental briefs as soon as possible, but no later than November 28, 1990.

ENTERED BY ORDER OF THE COURT

/s/ LEONARD GREEN,
Clerk

APPENDIX G

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
PIKEVILLE DIVISION

Civil Action No. 90-32

INTERNATIONAL RESOURCES, INC., ET AL.,
Plaintiffs

vs.

NEW YORK LIFE INSURANCE COMPANY,
Defendant.

ORDER
(Filed September 4, 1990)

The plaintiff, by counsel, having moved the court to reconsider its Memorandum Opinion and Order dated August 6, 1990, [Record No. 62]. Fully briefed [Record Nos. 63, 65 and 67] and ably argued, the matter is ripe for decision.

The pertinent facts are set forth in the Memorandum Opinion and Order dated August 6, 1990 [Record 59]. For the sake of brevity, they need not be recounted here.

The first question is whether the group health insurance plan issued by New York Life Insurance Company [New York Life] is an employee welfare benefit plan and, as such, covered by the Employee Retirement Income Security Act of 1974 [ERISA], 29 U.S.C. § 1001, *et seq.* This issue was fully discussed and considered earlier, the court holding that the plan in question is an ERISA welfare plan. The Fifth Circuit's recent decision in *Memorial Hospital System* v. *Northbrook Life Insurance Company*, 904 F.2d 236, 239-243 (5th Cir. 1990), serves to reinforce that holding.

The second issue is whether some of the plaintiffs' claims fall with the savings clause of ERISA, 29 U.S.C. § 1144(B)(2)(A). Again, this issue was fully discussed and considered earlier, the court holding that they were not. *See, e.g., Pilot Life Insurance Company* v. *Dedeaux*, 481 U.S. 41, 51-52, 54 and 56-57 (1987); *Varholla* v. *Doe*, 820 F.2d 809, 816-17 (6th Cir. 1987). Nothing further be said.

The court is aware that Kentucky law provides policyholders various remedies in disputes with their insurance companies. *See, e.g., Curry* v. *Fireman's Fund Insurance Company*, 784 S.W. 2d 176 (Ky. 1989); *State Farm Mutual Auto Insurance Company* v. *Reeder*, 763 S.W. 2d 116 (Ky. 1989); *Stevens* v. *Motorists Mutual Insurance Company*, 759 S.W. 2d 819 (Ky. 1988). The court is equally aware that ERISA does not provide remedies of the same breadth, *see, e.g., Varholla*, 820 F.2d at 816-817, but believes that it is up to the legislative branch to expand the remedies available to persons who establish an ERISA violation.

Accordingly, the plaintiffs' motion for reconsideration is granted, but the defendant's motion for summary judgment is granted nevertheless. The plaintiffs shall file an amended complaint, one setting forth an ERISA claim, within ten days from the date of entry of this order.

IT IS SO ORDERED this the 4th day of September, 1990.

/s/ JOSEPH M. HOOD,
JUDGE

Date of Entry and Service: Sept. 4, 1990

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
PIKEVILLE DIVISION

No. 90-32
Judge Joseph M. Hood

INTERNATIONAL RESOURCES, INC.;
and LARRY E. SMITH;

Plaintiffs,

v.

NEW YORK LIFE INSURANCE COMPANY,

Defendant.

ORDER
(Filed October 25, 1990)

Upon the motion of the Plaintiffs, and the court being duly advised, it is hereby

ORDERED that the Memorandum Opinion and Order entered herein on August 6, 1990 and the Order entered herein on September 4, 1990, be and are hereby amended to include the following additional paragraph:

> This Order involves controlling questions of law as to which there is substantial ground for difference of opinion, and an immediate appeal from this Order may materially advance the ultimate termination of the litigation. This determination is made pursuant to 28 U.S.C. § 1292(b) to permit application for an immediate interlocutory appeal from this Order.

Entered this 25th day of October, 1990.

/s/ JOSEPH M. HOOD,
JUDGE, UNITED STATES
DISTRICT COURT

APPENDIX H

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
PIKEVILLE

CIVIL ACTION NO. 90-32

INTERNATIONAL RESOURCES, INC., ET AL.,
Plaintiffs

vs.

NEW YORK LIFE INSURANCE COMPANY,
Defendant

MEMORANDUM OPINION AND ORDER
(Filed August 6, 1990)

The plaintiffs, International Resources, Inc. [International Resources] and Larry Smith [Smith], have brought the above-styled diversity action alleging violations of Kentucky contract and tort law by the defendant, New York Life Insurance [New York Life], stemming from its attempt to cancel coverage under a group health insurance policy issued to Smith. New York Life has moved to dismiss the plaintiffs' claims, asserting that they are preempted by the Employee Retirement Income Security Act of 1974 [ERISA], 29 U.S.C. § 1001 *et seq.* As later noted by the defendant, both parties have relied upon evidence outside the pleadings. The motion will, accordingly, be construed by the court as one for summary judgment.

International Resources was incorporated in Tennessee in 1982 by Smith and his wife as a small coal brokerage business. Smith is the corporation's president and has been the sole full-

time employee at least since 1986. Although his wife initially owned shares in the corporation, Smith now holds all of that stock. [Deposition of Larry Smith at 27]. The only other shareholder is an investor who was allowed to purchase twenty-five percent of the corporation's stock in 1983 after Smith's son, Paul Markham Smith [Mark], was involved in a serious automobile accident. [Depo. at 25-26]. The substantial continuing medical bills for Mark, who was left a quadriplegic by the accident, are at the center of this coverage dispute.

New York Life provided medical insurance to Smith and his dependents under a group coverage plan offered through Group Marketing Services Trust Administration [GMS]. GMS was a multiple employer trust which arranged with providers, such as New York Life, to offer discounted group insurance to a "group" of small, unrelated companies which would not otherwise be eligible for such coverage. International Resources first obtained employee health insurance, as well as life and disability coverge, through GMS in 1982. At that time, International Resources had six employees, including Smith, whose insurance was paid by the company as an automatic employee benefit. [Depo. at 33-36].

After Mark's accident, Smith was unable to sustain business at International Resources, resulting in the eventual exodus of all other employees. [Depo. at 87-88]. Four employees left by February, 1984. [Depo. at 49]. The fifth, Pamela Raines, worked as a secretary on a part-time basis through September, 1987. [Depo. at 88]. Smith's daughter was, as of February, 1990, employed on a part-time basis. [Depo. at 86-87]. It is unclear when Ms. Raines ceased to be included under the group health insurance policy or whether Smith's daughter was insured individually through International Resources.

New York Life became the GMS insurance provider beginning on March 1, 1986. [Depo., Defendant's Exhibit 12]. In August or September, 1988, Smith was notified that New York Life was terminating its coverage through GMS. International Resources terminated its GMS trust participation in

December, 1988. The plaintiffs, apparently unable to obtain comparable coverage, brought this action against New York Life seeking continued insurance benefits for Mark under the policy's terms for totally disabled persons and its one million dollar maximum lifetime benefit.

The court is limited at this point to review of the defendant's assertion that the insurance coverage provided through International Resources is a "plan" under ERISA, thus preempting the plaintiffs' state law claims. The plaintiffs argue that International Resources' act of purchasing insurance is insufficient to establish an ERISA plan. Regardless, the plaintiffs believe their claims are not preempted by the Act.

Where ERISA is applicable, it supercedes, with few exceptions, all state law relating to employee beneift plans. 29 U.S.C. § 1144; *Metropolitan Life Ins.* v. *Taylor*, 481 U.S. 58 (1987). The Act covers "employee welfare benefit plans," which are defined as:

> [A]ny plan, fund, or program which . . . is . . . established or maintained by an employer or by an employee organization, or by both, . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death, or unemployment . . . .

29 U.S.C. § 1002(1).[1] The central question in this case is whether the insurance obtained by International Resources for its employees through GMS constitutes "establishing or maintaining" a plan of insurance, or whether obtaining

[1] The federal Act is further limited to those employers "engaged in commerce or in any industry or activity affecting commerce" which establish or maintain benefit plans. 29 U.S.C. § 1003(a)(1). This prerequisite is not in question here.

coverage from a group marketing plan is simply the purchase of a policy of insurance not within the federal statute.[2]

The plaintiffs' position against ERISA coverage is grounded in the fact that International Resources had nothing to do with the insurance plan but to write a check to GMS. The company had no voice in management and operation of the plan. It is argued that ERISA was not intended to extend such circumstances.

The plaintiffs primarily rely on *Taggart Corp.* v. *Life and Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981). The *Taggart* court held that neither the group market service itself, nor the employer's subscription to such a service constitute the establishment of an ERISA "plan". *Id.* at 1211. "[W]e cannot believe that that Act regulates bare purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits." *Taggart*, 617 F.2d at 1211.

The *Taggart* court reasoned that the purpose of ERISA was to deter abuses of trust assets, particularly in private pension plans. It was further noted that Congress has elsewhere, specifically under tax law, treated health *insurance* as distinct from health *plans*. Thus, the court concluded that the use of the word "plan" under ERISA, in light of the Act's protective purpose, involves a broader concept than the pure insurance

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[2] The parties separately briefed the issue of whether Smith, as majority shareholder, president, and sole full-time employee could be considered an "employee" in analyzing whether an ERISA plan existed. *Kwatcher* v. *Massachusetts Service Employees Pension Fund*, 879 F.2d 957 (1st Cir. 1989); *Dodd* v. *John Hancock Mutual Life Ins. Co.*, 688 F.Supp. 564 (E.D. Cal. 1988). The defendant has pointed out that the Sixth Circuit recognizes the corporation to be the "employer" distinct from its owner-chief executive. *See Scarbrough* v. *Perez*, 870 F.2d 1079, 1083 (6th Cir. 1989) (holding that owner-executives are not personally liable for delinquent contributions to an ERISA plan). This analysis is consistent with the holding in *Dodd*. Thus, Smith must be considered an "employee" for this analysis.

transactions involving no more than "making payments to a purveyor of insurance". *Taggart*, 617 F.2d at 1211.

This conclusion in *Taggart* was rejected by the court in *Donovan* v. *Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (*en banc*), the principle case relied upon by the defendant. Although the *Donovan* court agreed that the group marketing service itself does not qualify as an ERISA "plan", it went on to hold that surrounding circumstances may prove a plan under ERISA to have been "established" by an employer's subscription to a group marketing plan. *Id.* at 1373.

The court recognized, consistent with *Taggart*, that no single act, such as the purchase of insurance, conclusively establishes a plan. *See also Terry* v. *Protective Life Ins. Co.*, 717 F. Supp. 1303, 1205 (S.D. Miss. 1989) (insufficient facts to show employer's purchase of group insurance established a plan). In fact, an employer may be involved in a plan, such as permitting an insurer to publicize a program, collecting premiums through payroll deduction, and remitting those premiums to the insurer, without "establishing" a plan. 29 C.F.R. § 2510.3-1(j); *Donovan*, 688 F.2d at 1373 n.11.

The *Donovan* rule requires a determination of "whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." *Donovan*, 688 F.2d at 1373. The court went on to point out that "[s]ome essentials of a plan . . . can be adopted, explicitly or implicitly, from sources outside the plan, fund, or program — e.g., an insurance company's procedure from processing claims. . . ." *Donovan*, 688 F.2d at 1373.

The result in *Donovan*, and subsequent cases adopting its view, indicates that an employer can establish an ERISA plan "rather easily." *See Credit Managers Ass'n* v. *Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987). The *Donovan* court found numerous subscribers to the multiple employer trust in that case to have established ERISA plans. Some employers had furnished insurance for employees pursuant to an agreement or a continuing practice, and others purchased benefits for a substantial percentage of a class of

employees under circumstances tending to show an anticipated continuing furnishing of health benefits. *Donovan*, 688 F.2d at 1374-75.

Although *Taggart* has been accepted by other courts for its conclusion as to the ERISA status of multiple employer insurance trusts, *see, e.g., Matthew 25 Ministries, Inc.* v. *Corcoran*, 771 F2d 21 (2nd Cir. 1985), it is the *Donovan* analysis which this court finds compelling in the establishment of an ERISA plan by employers. The *Donovan* test promotes an analysis of the employer's actions, rather than the blanket preclusion called for in *Taggart*. More importantly, the inclusive approach of *Donovan* is consistent with the broad scope of ERISA.

In *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 46 (1987), the United States Supreme Court stressed that the "express preemption provisions of ERISA are deliberately expansive," noting Representative Dent's remark that " 'reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans' as ERISA's 'crowning achievement.' " The intent to invoke broad federal preemptive power over benefit plans would be meaningless if the "establishment" of an ERISA plan was limited. In fact, the type of insurance plan in which International Resources enrolled is "a common method by which employers provide health and other welfare benefits to their employees, and not one that has heretofore been thought to take a benefits plan out of ERISA." *Brundage-Peterson* v. *Compcare Health Services Ins. Corp.*, 877 F.2d 509, 511 (7th Cir. 1989).

In *Brundage-Peterson*, the employee argued that a medical insurance plan offered by her employer to virtually all employees, paid for by the employer, was not an ERISA plan. The employer contracted with two insurance providers to offer health insurance at terms specified in the contracts, including the price. The employees were given the option between insurance plans and the employer paid the employee's individual premium. The court held this "rather barebones plan" to be an ERISA plan, finding that:

> [a]n employer who creates by contract with an insurance company a group insurance plan and designates which employees are eligible to enroll in it is outside the safe harbor created by the Department of Labor regulation [29 C.F.R. § 2510.3-1(j)]. This is especially clear when in addition, as was done here, the employer helps defray the employee's insurance cost . . . .

Brundage-Peterson, 877 F.2d at 511.

The court in *Brundage-Peterson* particularly noted that the statute "by its express terms encompasses the provision of such benefits by means of insurance." 877 F.2d at 511. The ERISA definition of "employee welfare benefit plan" specifically allows that the plan for providing health benefits may be established "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1).

The circumstances of this case nearly parallel those in *Brundage-Peterson* and *Donovan*. International Resources contracted with a provider for employee insurance coverage, including selection of terms and price. All employees were automatically covered and the company paid the insurance premiums. The intended benefits, the class of beneficiaries, the source of financing, and the procedure for receiving benefits are all easily ascertainable. Thus, International Resources established an ERISA plan by contracting with GMS.

The plaintiffs believe that since Smith is now the sole full-time employee, the "plan" was merely the purchase of insurance by an individual. However, there is no authority for the proposition that a health insurance plan, once covered by ERISA, ceases to be within the scope of the Act because the number of employees dwindled under adverse economic circumstances. The company did not drop the insurance plan, it lost the employees. Continued enrollment through International Resources sustained the plan. There is no indication in the record that the same insurance plan would not have been offered to another full-time employee if hired.

The plaintiffs contend that, regardless of the existence of an ERISA plan, certain of their claims are not preempted because the claims relate to "benefits" as opposed to the "plan." They point out that this distinction in terminology was recognized by the United States Supreme Court in *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1 (1987). However, the interpretation of *Fort Halifax* urged by the plaintiffs has been rejected by the Sixth Circuit. *McMahan* v. *New England Mutual Life Ins. Co.*, 888 F.2d 426 (6th Cir. 1989). The court, quoting *Fort Halifax*, noted that even state laws relating to benefits have been held preempted by ERISA "where the state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements." *McMahan*, 888 F.2d at 428 (quoting *Fort Halifax*, 482 U.S. at 10.)

The *McMahan* court went on to hold that "[w]e think it clear that subjecting an ERISA fiduciary to the vagaries of state contract law regarding its benefits decisions would create the very real prospect that the fiduciary's administrative scheme would be subject to conflicting requirements in the various states." 888 F.2d at 429. The same principle is applicable to the plaintiffs' claims in this instance.

The plaintiffs plead that the ERISA preemption leaves them with less protection against the insurer's refusal to pay benefits than under state law, despite the remedial purpose of the Act. Regardless, preemption is the intended result of Congress in circumstances such as this. The court is constrained by the Act and regulations thereunder to rule in conformity with them, despite what the court in *Brundage-Peterson* terms the "strangeness" of transforming such contract disputes into suits under ERISA.

The defendant agrees that the plaintiffs can restructure their complaint on these facts to conform with ERISA. Further, such an amendment will appropriately frame the merits under ERISA of this insurance coverage dispute. Accordingly,

IT IS ORDERED HEREIN AS FOLLOWS:

(1) that the defendant's motion for summary judgment be, and the same hereby is, GRANTED.

(2) that the plaintiffs shall be granted until August 24, 1990 to file an amended complaint.

This the 6th day of August, 1990.

/s/ JOSEPH M. HOOD
JUDGE

Date of Entry and Service: August 6, 1990

APPENDIX I

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
PIKEVILLE

CIVIL ACTION NO. 90-32

INTERNATIONAL RESOURCES, INC, *ET AL.*,
PLAINTIFFS,

v.

NEW YORK LIFE INSURANCE COMPANY,
DEFENDANT.

MEMORANDUM OPINION
(Filed March 5, 1990)

This matter is before the court on the motion of plaintiffs for preliminary injunction. The defendant has filed a response objecting to the motion, to which the plaintiffs have filed a reply. The Court conducted a hearing in this matter on March 2, 1990.

FACTUAL BACKGROUND

The plaintiffs filed this action seeking declaratory and other relief for injuries arising out of the attempted cancellation of a group policy issued by defendant, New York Life Insurance Company ["New York Life"]. Plaintiff Larry Smith and his dependents (including his quadriplegic son, Mark Smith) are insured under the policy for major medical expenses. The plaintiffs seek a declaration that the purported cancellation of the group policy does not relieve New York Life of liability for subsequent hospital, medical, nursing and home health care expenses incurred on behalf of Mark as a

result of a condition that occurred and existed prior to the purported cancellation of the policy.

The plaintiffs also seek compensatory and punitive damages from New York Life for breach of its insurance contract, for bad faith and breach of fiduciary duty, for breach of an implied covenant of good faith and fair dealing, for various statutory violations, and for violation of the public policy against illusory insurance contracts.

This Court previously sustained the plaintiffs' motion for a temporary restraining order, and an agreed order was entered whereby New York Life was to pay the medical expense incurred for Mark during the period up through the hearing on March 2, 1990.

The plaintiff Mr. Smith is president of the plaintiff International Resources, Inc. ["International Resources"]. In November 1982, International Resources contracted with Life Insurance Company of North America ["INA"] for comprehensive group medical insurance coverage for International Resources' employees effective December 1, 1982. This insurance was arranged by Group Marketing Services, Inc. ["GMS"], adminsitered by Group Marketing Services Trust Administration ["GMS Trust"] and underwritten by INA.

The coverage provided by INA was described in a certificate or booklet given to the plaintiffs. On April 1, 1983, Trans Pacific Life Insurance Company ["Trans Pacific"] succeeded INA as the underwriter on the insurance provided through GMS. Trans Pacific did not supply a separate booklet but continued to provide coverage as described in the initial booklet from INA.

On May 8, 1983, Smith's son and dependent, Mark, was severely injured in an automobile accident which left him completely immobile, unable to speak, and in need of 24-hour nursing and home health care.

On March 1, 1986, New York Life succeeded Trans Pacific as the underwriter on the insurance coverage provided through GMS. New York Life mailed the Certificate of Insurance to International Resources. All premiums were paid at that time to New York Life.

New York Life paid the costs and expenses of medical care for Mark, subject to applicable deductibles and co-payments, until October 1, 1989. Since that time, New York Life had refused to pay the expenses for Mark's medical treatment, which costs approximately $100,000 per year. New York Life's refusal to pay is based on its cancellation of the group policy, purportedly effective October 1, 1988, with continuation benefits through October 1, 1989.

Plaintiffs argue that the insurance contract issued by New York Life promised lifetime benefits of up to $1,000,000. As of the date New York Life ceased payments, approximately $425,000 in benefits remained to be supplied toward the one million dollar figure. The current issue before the Court essentially focuses on the $1,800-$2,000 per week cost of caring for Mark while this litigation is pending.

Various affidavits, depositions, testimony and exhibits have been offered as to the pertinent facts of this matter. The Court has reviewed this matter and concludes that plaintiffs have demonstrated entitlement to a preliminary injunction. In this regard, the Court preliminarily finds that qualified home nursing care is difficult to find and Smith is not able to compete with other potential employers because of the circumstances in which New York Life has placed him.

One nurse has already left her position in caring for Mark and his other nurses are expected to seek more secure employment shortly. Currently, Mark's care is down to two nurses (an LPN and an RN). Since one nurse had been ill recently, Smith's wife and one nurse have been caring for Mark. Mark's care entails a great deal of work since Mark is unable to perform any task for himself. In fact, Mark must be moved around and exercised approximately every 1½ hours to avoid sores associated with long-term bed confinement.

The state of North Carolina has provided some limited Medicaid benefits, called Home Health Aid. This consists of assistants who visit mark only Monday through Friday. They can only bathe and dress Mark but apparently cannot administer food, water or some medications. Medicare will apparently not pay any bills for private duty nursing. Mr. Smith

testified that his experience has shown that $8,000 per month for private duty nursing is cheaper than employment of nursing services.

Plaintiffs have submitted the affidavit of Mark's attending physician, Dr. Jacqueline K. DuSold. Dr. DuSold states that Mark "requires individualized nursing and medical attention on a daily and routine basis." The defendant does not appear to contest that the home nursing care is medically necessary. Dr. DuSold also emphasizes the problems generated by turnover in Mark's caretakers, which can result from insecurity as to financial resources.

DISCUSSION

The issuance of a preliminary injunction centers on a well-known four-prong test:

> 1) Whether the movant has shown a strong or substantial likelihood or probability of success on the merits;
>
> 2) Whether the movant has shown irreparable harm or injury;
>
> 3) Whether the preliminary injunction would cause substantial harm to others; and
>
> 4) Whether the public interest would be served by issuing the preliminary injunction.

USACO Coal Co. v. Carbomin Energy, Inc., 689 F.2d 94, 98 (6th Cir. 1982). These factors are to be balanced by the Court in arriving at its decision.

A. Plaintiffs Have Shown Substantial Likelihood of Success on the Merits

The defendant argues in its response to the motion that this matter is controlled by the provisions of ERISA. However, although this Court is not certain that ERISA applies to the circumstances of this insurance policy, the Court feels the

plaintiffs have shown a substantial likelihood of success on the merits from within the four corners of the insurance contract, notwithstanding application of ERISA. Therefore, the Court does not find it necessary to treat the ERISA issues at this time.[1]

Plaintiffs appear to be entitled to relief against New York Life for breach of the express provisions of the insurance contract. The New York Life insurance contract provides that New York Life will pay to Smith lifetime benefits for covered medical expenses up to $1,000,000. As of the date New York Life ceased paying, approximately $575,000 had been paid, leaving an additional $425,000 in benefits to be supplied in accordance with the insurance contract.

The New York Life Certificate states on page 6 under the heading "When Does Coverage End?," as follows:

> All coverage ends when you cease to be eligible. Coverage for any of your insured dependents ends when that person ceases to be eligible. *However, if a person is totally disabled when coverage ends, benefits may continue for covered expenses due to the condition which caused the disability.* [Emphasis added].

The New York Life Certificate also states on page 48 under the heading "Effect of Prior Plan Coverage" that "the main purpose is to avoid gaps in coverage that might otherwise occur because of the change in plans." It goes on to explain at page 50 that for a dependent (such as Mark) who is confined at home on the Plan's effective date, New York Life will pay benefits as follows: "MAJOR MEDICAL AND HOSPICE CARE INSURANCE — The amount the prior plan would have paid."

New York Life's Certificate provided that benefits were continued under its policy. The coverage continued by New York Life can be found in the booklet provided by INA,

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[1] The defendant has filed a motion to dismiss regarding the application of ERISA.

under which INA and Trans Pacific[2] had paid benefits for approximately three years before New York Life took over, and which similarly promised a "maximum lifetime benefit" of $1 million. The INA coverage, incorporated by the New York Life booklet's reference to what "the prior plan would have paid," also provided:

> If an unmarried dependent child . . . is physically incapable of self-sustaining employment on the date he would otherwise cease to be a "dependent" as defined herein, *an Individual's insurance with respect to such dependent child shall not terminate as long as the Individual's insurance remains in force and as long as such incapacity continues.* . . .

INA Booklet, at 7 (emphasis added).

Given these express terms of the New York Life contract (and the INA certificate it incorporated by reference), New York Life appears obligated to provide the coverage suggested by the plaintiffs. Therefore, the plaintiffs have met their burden of demonstrating a probability of success on the merits. Furthermore, to the extent defendant argues that other language in the insurance contract allows for complete cancellation of the policy, the plaintiffs are entitled to have such ambiguity resolved in their favor pursuant to well-accepted principles of contract construction.

B. Plaintiffs Have Shown Irreparable Injury

The plaintiffs have clearly shown that irreparable injury will occur if New York Life is not enjoined from refusing to pay Mark's medical expenses. Mark's health demands generate a great deal of expenses. The loss of these funds would impose substantial detriment to the maintenance of Mark's medical needs.

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[2] Trans Pacific did not issue its own booklet but continued to provide coverage under the terms of the INA certificate.

Even more important is the effect that New York Life's failure to pay for Mark's care is having on Smith's ability to attract and retain quaiified nurses to care for Mark. The employment to care for Mark is no longer perceived as being stable or secure because of the lack of insurance coverage, and has made it difficult for Mr. Smith to compete with other potential employers for the same nurses.

Dr. DuSold's affidavit demonstrates that interruption of this medically necessary care can be expected, within a reasonable medical probability, to cause Mark to suffer irreversible physical care due to his fragile state. If New York Life's conduct is not enjoined, it will shortly result in a total lack of home nursing care for Mark, either through lack of financial resources or through unavailability of nurses. Thus, the need is crucial for the Court's injunction at this stage to prevent irreparable harm for which there is no adequate remedy at law.

C. No Harm Imposed on the Defendant

The issuance of a preliminary injunction will not impose a serious burden on the defendant in this case. The primary reason is because even if the Court is incorrect regarding the probability of success on the merits, and the injunction is improvidently granted, the defendant will be protected by the posting of a bond by the plaintiffs for an amount equal to that paid by the defendant pursuant to the injunction. Any loss would only be monetary loss which can be fully protected by a bond.

The injunction will only direct the defendant to continue paying the amounts it has been paying since it assumed the policy. The parties have previously discussed an incremental bond where the plaintiffs would continually increase the posted bond commensurate with the amount paid by the defendants. The Court favors this approach in protecting the rights of the defendant in the event the injunction is improvidently granted.

D. Other Considerations Do Not Militate Against Issuance

The issuance of a preliminary injunction is not hindered by other considerations. For example, the issuance of a preliminary injunction will not cause substantial harm to others. The injunction will only affect the immediate parties to this action. Furthermore, the public interest is not an issue in this case. If anything, the public interest weighs heavily in favor of issuing the preliminary injunction.

There is an obvious need in this case to expeditiously resolve the merits. The type of harm posed in this case, in conjunction with the likelihood of success on the merits, all suggest the need for the injunctive relief requested. Furthermore, no public interests suggest otherwise.

CONCLUSION

For the foregoing reasons, it is hereby ORDERED that the plaintiffs' motion for preliminary injunction is GRANTED. A Preliminary Injunction in conformity with this Memorandum Opinion shall be entered contemporaneously herewith.

This 5th day of March, 1990.

/s/ KARL S. FORESTER,
JUDGE

Date of Entry and Service: March 6, 1990

APPENDIX J

STATUTORY PROVISIONS

29 USC § 1002 Definitions

For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USC § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).

APPENDICES K, L, M

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29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USC § 1003(a)] and not exempt under section 4(b) [29 USC § 1003(b)]. This section shall take effect on January 1, 1975.

(b) Construction and application. (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law or any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a) [29 USC § 1003(a)], which is not exempt under section 4(b) [29 USC § 1003(b)] (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

APPENDIX N

[KRS] 304.12-230. **Unfair claims settlement practices.** — It is an unfair claims settlement practice for any person to commit or perform any of the following acts or omissions:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(7) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(8) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(10) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made;

(11) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or

claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(14) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. (Enact. Acts 1984, ch. 171, § 2, effective July 13, 1984; 1988, ch. 225, § 19, effective July 15, 1988.)

APPENDIX O

[KRS] 367.170. Unlawful acts. — (1) Unfair, false, misleading, or deceptive acts or practices in the conduct of any trade or commerce are hereby declared unlawful.

(2) For the purposes of this section, unfair shall be construed to mean unconscionable. (Enact. Acts 1972, ch. 4, § 7; 1976, ch. 221, § 1.)

* * * *

[KRS] 367.220. Action for recovery of money or property — When action may be brought. — (1) Any person who purchases or leases goods or services primarily for personal, family or household purposes and thereby suffers any ascertainable loss of money or property, real or personal, as a result of the use or employment by another person of a method, act or practice declared unlawful by KRS 367.170, may bring an action under the Rules of Civil Procedure in the circuit court in which the seller or lessor resides or has his principal place of business or is doing business, or in the circuit court in which the purchaser or lessee of goods or services resided, or where the transaction in question occurred, to recover actual damages. The court may, in its discretion, award actual damages and may provide such equitable relief as it deems necessary or proper. Nothing in this subsection shall be construed to limit a person's right to seek punitive damages where appropriate.

APPENDIX P

[KRS] 304.12-010. Unfair competition — Unfair, deceptive practices prohibited. — No person shall engage in this state in any practice which is prohibited in this subtitle, or which is defined therein as, or determined pursuant thereto to be, an unfair method of competition or any unfair or deceptive act or practice in the business of insurance. (Enact. Acts 1970, ch. 301, subtitle 12, § 1.)

* * * *

[KRS] 304.12-020. Advertisements in general. — No person shall make or disseminate orally or in other manner any advertisement, information, matter, statement or thing:

(1) Misrepresenting the terms of any policy or the benefits or advantages thereof or dividends or share of surplus to be received thereon, or setting forth false or misleading information or estimates as to dividends or share of surplus previously paid on similar policies.

(2) Using any name or title of any policy or class of policies misrepresenting the true nature thereof.

(3) Setting forth any misleading representation or any misrepresentation as to the financial condition of an insurer, or as to the legal reserve system upon which any life insurer operates.

(4) Containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading. (Enact. Acts 1970, ch. 301, subtitle 12, § 2.)

APPENDIX Q

[KRS] 304.18-110:

* * *

(5) Group members have the right upon termination of coverage under a group policy for any reason to have a conversion health insurance policy providing substantially similar benefits issued to the group member by the insurer upon meeting the following conditions:

(a) The group member has been covered by the group policy or any policy it replaced for at least three (3) months;

(b) The group member must make written application to the insurer for conversion health insurance coverage not later than thirty-one (31) days after notice pursuant to subsection (9) of this section; and

(c) The group member must pay the monthly, quarterly, semiannual, or annual premium, at the option of the applicant, to the insurer not later than thirty-one (31) days after notice pursuant to subsection (9) of this section.

APPENDIX R

[KRS] 446.070. **Penalty no bar to civil recovery.** — A person injured by the violation of any statute may recover from the offender such damages as he sustained by reason of the violation, although a penalty or forfeiture is imposed for such violation. (466).